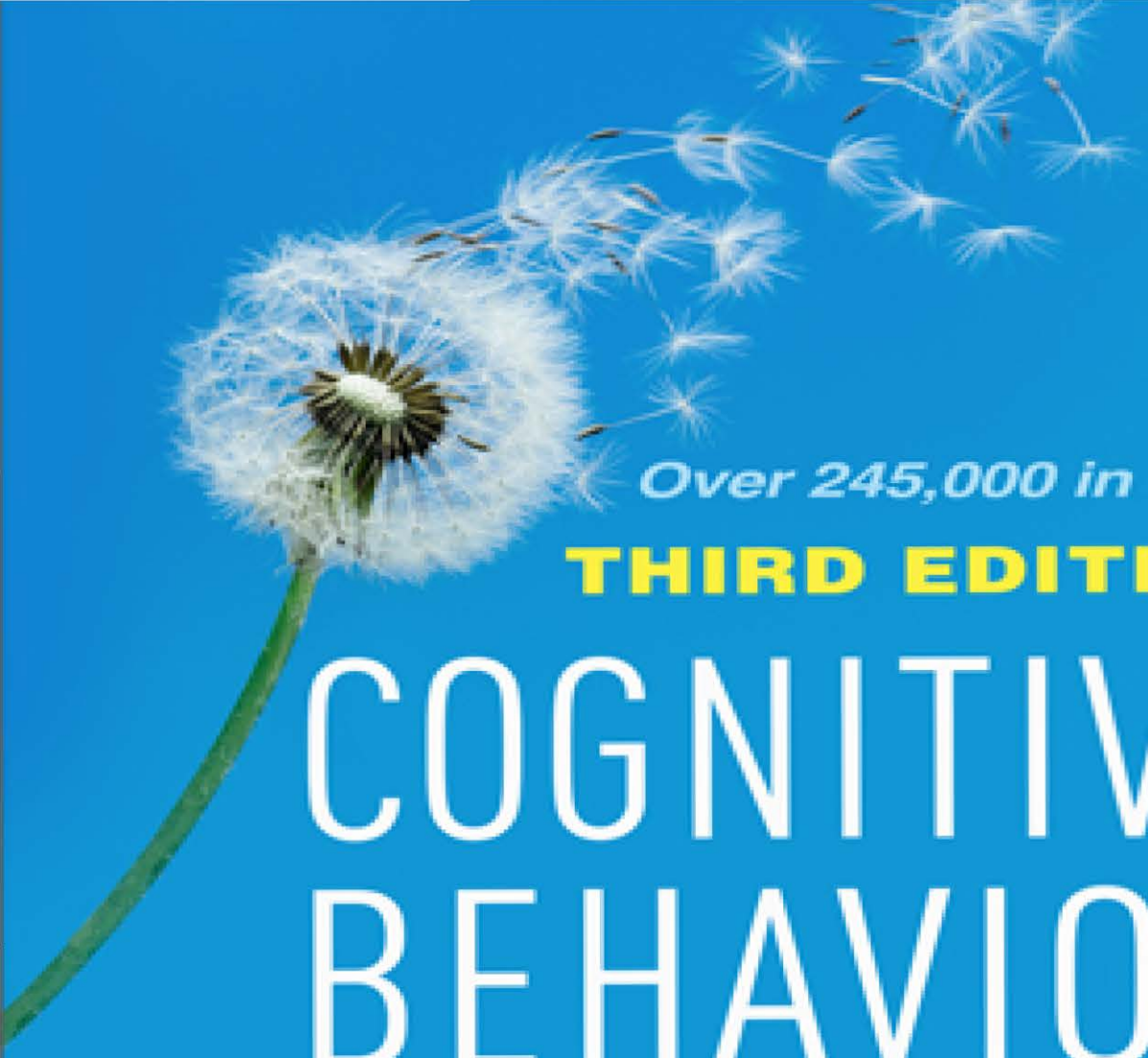

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COGNITIVE BEHAVIOR THERAPY

BASICS AND BEYOND

Judith S. Beck

Foreword by **Aaron T. Beck**

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Cognitive Therapy for Challenging Problems: What to Do When the Basics Don't Work

COGNITIVE BEHAVIOR THERAPY

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To my father, Aaron T. Beck,
and the wonderful staff of
the Beck Institute for Cognitive Behavior Therapy

ABOUT THE AUTHOR

Judith S. Beck, PhD, is President of the Beck Institute for Cognitive Behavior Therapy (*www.beckinstitute.org*), a nonprofit organization that provides state-of-the-art training and certification in CBT to individuals and organizations, offers online courses on a variety of CBT topics, conducts research, and serves as a leading global resource in CBT. She is also Clinical Professor of Psychology in Psychiatry at the University of Pennsylvania Perelman School of Medicine. Dr. Beck has written over 100 articles and chapters as well as several books for professionals and general readers, including *Cognitive Therapy for Challenging Problems: What to Do When the Basics Don't Work*. She has made hundreds of presentations around the world on topics related to CBT, is codeveloper of the Beck Youth Inventories and the Personality Belief Questionnaire, and has won numerous awards for her contributions to the field. She also continues to treat clients at the Beck Institute's in-house clinic in suburban Philadelphia.

FOREWORD

I am delighted that this third edition of *Cognitive Behavior Therapy: Basics and Beyond* is being published. The field of cognitive behavior therapy (CBT) has grown by leaps and bounds in the past decade alone. One factor that makes this new edition so valuable is its adaptation of techniques from a wide variety of psychotherapies into treatment, in the context of the cognitive model. You'll find important interventions from acceptance and commitment therapy, dialectical behavior therapy, mindfulness-based cognitive therapy, and others. Equally important, though, is its emphasis on a recovery or strengths-based orientation as part of the foundation of CBT. A single depressed client is followed throughout the book, along with opportunities to stream the videos of therapy sessions and download worksheets. A second, more complex client is also portrayed throughout the book to illustrate variations of treatment when difficulties arise.

When I first developed cognitive therapy in the 1960s and 1970s, I focused the conceptualization and treatment of individuals on their problems, negative cognitions, and dysfunctional coping strategies. By the mid-1980s, I could claim that cognitive therapy had attained the status of a "system of psychotherapy." It consisted of (1) a theory of personality and psychopathology with solid empirical findings to support its basic postulates; (2) a model of psychotherapy with sets of principles and strategies that blended with the theory of psychopathology; and (3) solid

empirical findings based on clinical outcome studies to support the efficacy of this approach.

Now, at the start of the third decade of the third millennium, we have developed a different focus in conceptualization and treatment. While negative aspects of individuals' experiences are still important, it is at least equally important to conceptualize individuals' aspirations, values, goals, strengths, and resources, and to incorporate these positive characteristics in helping them to take specific steps that are linked to what is most important to them. It's also critical to anticipate obstacles to taking these steps, to use basic CBT skills (such as cognitive restructuring, problem solving, and skills training) to overcome the obstacles, and to help individuals draw positive conclusions about what their experiences say about them.

This third edition of the basic text in the field offers readers fresh insights into 21st-century CBT and will be important for those who are already proficient in traditional CBT as well as students new to the field. Given the tremendous amount of new research and expansion of ideas that continue to move the field in exciting new directions, I applaud the efforts to expand this volume to incorporate some of the different ways of conceptualizing and treating our clients.

The applications of CBT to a host of psychological and medical disorders extend far beyond anything I could have imagined when I treated my first few depressed and anxious clients with cognitive therapy. The formidable array of different applications of CBT is based on fundamental principles outlined in this volume. This book was written by Dr. Judith Beck, one of the foremost second-generation CBT educators, who, as a teenager, was one of the first to listen to me expound on my new theory. It will help aspiring therapists to learn the cutting-edge nuts and bolts of this therapy. Even CBT therapists who are skilled at delivering traditional CBT should find this book quite helpful in adopting a strengths-based approach, sharpening their conceptualization skills, expanding their repertoire of therapeutic techniques, planning more effective treatment, and troubleshooting difficulties in therapy. Of course, no book can substitute for supervision in CBT. But this book is an important volume and can enrich the supervision experience.

Dr. Judith Beck is eminently qualified to offer this guide to CBT. For the past 35 years, she has conducted many hundreds of workshops and

trainings in CBT all over the world as well as online, supervised both beginners and experienced therapists, helped develop treatment protocols for various disorders, and participated actively in CBT research. With such a background to draw on, she has written a book with a rich lode of information to apply this therapy, the earlier editions of which have been the leading CBT texts in most graduate psychology, psychiatry, social work, and counseling programs.

The practice of CBT is not simple. Too many mental health professionals call themselves CBT therapists but lack even the most basic conceptual and treatment skills. The purpose of Dr. Judith Beck's book is to educate, to teach, and to train both the novice and the experienced therapist in CBT, and she has succeeded admirably in this mission.

AARON T. BECK, MD

PREFACE

I'm excited to introduce this third edition of *Cognitive Behavior Therapy: Basics and Beyond* to you. Before beginning this revision, I asked for feedback on the second edition from health and mental health practitioners all over the world. What would they like to see improved? What worked and what didn't? The responses I received were excellent and really helped me conceptualize the changes and additions I chose to make. This edition incorporates the feedback I received from many readers and reflects the most recent research and current directions for the field of cognitive behavior therapy (CBT).

Readers consistently commented that they wanted to see a more complex client to serve as the key example throughout the book. "Abe," the client illustration in this edition, is more severely depressed than "Sally," the client who appeared throughout the second edition. In addition to depression, Abe also struggles with moderate anxiety and complicating problems including unemployment and a recent divorce. I have also included a second client example, "Maria," who has borderline personality traits. I've included links so you can watch videos of full and partial therapy sessions with Abe and you can download worksheets.

Another important change is that I've revised much of the material to include both our traditional orientation and also a recovery orientation. Recovery-oriented cognitive therapy (CT-R) is a cutting-edge evidence-based treatment for individuals diagnosed with severe mental illness, including schizophrenia, many of whom have been hospitalized for

decades. CT-R was developed, and is currently being researched, by my father, Dr. Aaron T. Beck, and his research/training group, which is now part of the Beck Institute for Cognitive Behavior Therapy. Our other clinician/educators and I have been adapting this approach for use with our nonhospitalized clients who experience a wide range of psychiatric disorders, psychological problems, and medical conditions with psychological components. The recovery orientation focuses on identifying clients' values and aspirations (and the meaning of their aspirations) and helping them create a sense of purpose and empowerment in their lives by taking steps each week in pursuit of their goals. We also focus on helping clients reach positive conclusions about themselves, others, and their future as a result of taking these positive actions, and we identify and reinforce their positive qualities, skills, and resources. We emphasize experiencing positive emotion both in and out of sessions. We expect that the recovery movement will play a large role in shaping the future of CBT, and psychotherapy in general, in the coming years and decades.

Finally, I have written this edition in a more reader-friendly style. When I teach workshops at the Beck Institute in Philadelphia, or online courses, I often include anecdotes from my own clinical practice. I also encourage participants to take part in interactive activities, where I ask them to role-play with another participant, respond to questions, and present their own challenging cases for feedback and discussion. Most participants find these interactive components to be very meaningful and inspiring. In this edition of the book, I not only use a more personal approach in my writing but also have included clinical tips from my own practice, reflection questions, and suggested activities to help readers engage with the material.

I hope you enjoy reading this book as much as I enjoyed writing it. I always say that learning CBT is a lifelong endeavor. No matter where you are on your journey, I hope this book inspires you to learn more about CBT.

ACKNOWLEDGMENTS

At the age of 98, Aaron Beck, my father, is still teaching me about cognitive behavior therapy (CBT). Most recently, he and our colleagues at the Beck Institute for Cognitive Behavior Therapy, in suburban Philadelphia, have developed, and are researching, recovery-oriented cognitive therapy (CT-R) for individuals diagnosed with serious mental health conditions. I have been applying CT-R to the clients I treat in our outpatient clinic with great results. I'm very excited about this new development in the field, with its emphasis on motivating clients through identifying their aspirations and values, meaning and purpose; focusing on their strengths and resources; helping them overcome obstacles to working toward their aspirations each week; and drawing positive conclusions about their experiences and themselves. I am grateful to my father and to our CT-R team, headed by Paul Grant and Ellen Inverso, for inspiring the recovery orientation I have included in this book.

I am equally fortunate to interact with our team of excellent clinicians, Rob Hindman, Norman Cotterell, Fran Broder, and Allen Miller. They treat clients, teach at our workshops, supervise therapists (from beginners to experts), and participate in program development. I learn so much by discussing my clients with them every week at our case conferences. They and Brianna Bliss helped improve this manuscript.

I am also grateful to Lisa Pote who has transformed the Beck Institute into a worldwide training and resource center, and Kitty Moore of The Guilford Press, who has been my friend and editor for nearly 25 years.

And great thanks to my husband, Richard Busis, who provided daily encouragement and final edits to the manuscript.

And a last note of overwhelming gratitude to my most excellent and wonderful assistant, Sarah Fleming, who helped in immeasurable ways in getting this book to press.

Thank you all.

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Also by Judith S. Beck

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INTRODUCTION TO COGNITIVE BEHAVIOR THERAPY

Abe[1] is a 55-year-old divorced man of European heritage who became severely depressed over 2 years ago, following very significant difficulties at work and in his marriage. By the time I started treating him, he was fairly isolated and inactive, spending most of his time in his apartment, watching television and surfing the net, and occasionally playing video games.

Abe and I met for a total of 18 sessions over 8 months, using both a traditional cognitive behavior therapy (CBT) and a recovery-oriented cognitive therapy (CT-R) conceptualization and corresponding interventions. You'll read more about the recovery orientation in this chapter and throughout the book. First, I conducted a diagnostic evaluation. In the next session, our first treatment session, I gave Abe information about his diagnosis, the theory of CBT, the process of therapy, and my proposed treatment plan. I asked about his aspirations (how he wanted his life to be) and values (what was really important to him) and then we set goals. Abe wanted to have a better life, to be productive and helpful to others, and to be optimistic, resilient, and in control. More specifically, it was important to him to manage better at home, find a job, improve the relationships with his ex-wife and children, reconnect with friends, start going to church again, and get in shape. We discussed how he could become more active in the coming week and agreed on an Action Plan (therapy "homework"). Then I elicited Abe's reaction to the session.

The major part of each subsequent session focused on helping Abe identify his goals for the session, decide what steps he wanted to take in the coming week, create solutions to potential obstacles, reduce negative mood, and increase positive mood. We often did problem solving and skill building, especially skills related to changing his depressed thinking and behavior. I not only used various interventions with Abe but also taught him how to use these skills himself, to build resilience and prevent relapse. The structure and techniques we used were essential as was the development of a good therapeutic relationship. You'll be learning much more about Abe and his treatment throughout this book.

You'll also follow Maria[2] throughout this book. Maria is 37 years old. She has recurrent severe depression and traits of borderline personality disorder. Her treatment was much more complex and lasted a good deal longer. Maria saw herself as helpless, inferior, unlovable, and emotionally vulnerable. She viewed others as potentially critical, uncaring, and likely to hurt her. These beliefs were often triggered during our sessions. Initially she was quite suspicious of me, on guard lest I harm her in some way. It was much more difficult to establish a strong therapeutic relationship with Maria. Her intense hopelessness and anxiety about therapy and about me interfered with her fully engaging in treatment for quite a while. While Abe's treatment exemplifies a standard approach, I had to adapt treatment considerably for Maria.

In the rest of this chapter, you'll find answers to the following questions:

- What is CBT?
- What is the theory behind CBT?
- What does research tell us about its effectiveness?
- How was it developed?
- What is CT-R?
- What does a typical cognitive intervention look like?
- How can you become an effective CBT therapist?
- How can you best use this book?

WHAT IS CBT?

Aaron Beck developed a form of psychotherapy in the 1960s and 1970s that he originally named "cognitive therapy," a term that is often used synonymously with "cognitive behavior therapy" (CBT) by much of our field. Beck devised a structured, short-term, present-oriented psychotherapy for depression (Beck, 1964). Since that time, he and others around the world have successfully adapted this therapy to a surprisingly diverse set of populations with a wide range of disorders and problems, in many settings and formats. These adaptations have changed the focus, techniques, and length of treatment, but the theoretical assumptions themselves have remained constant.

In all forms of CBT that are derived from Beck's model, clinicians base treatment on a cognitive formulation: the maladaptive beliefs, behavioral strategies, and maintaining factors that characterize a specific disorder (Alford & Beck, 1997). You will also base treatment on your conceptualization, or understanding, of individual clients and their specific underlying beliefs and patterns of behavior. One of Abe's underlying negative beliefs was "I'm a failure," and he engaged in extensive behavioral avoidance so his (perceived) incompetence, or failure, wouldn't be apparent. But his avoidance ironically strengthened his belief of failure.

Originally trained as a psychoanalyst, Beck drew on multiple sources when he developed this form of psychotherapy, including early philosophers, such as Epictetus, and theorists, such as Karen Horney, Alfred Adler, George Kelly, Albert Ellis, Richard Lazarus, Albert Bandura, and many others. Beck's work, in turn, has been expanded by a host of researchers and theorists, too numerous to recount here, in the United States and abroad. Historical overviews of the field provide a rich description of how the different streams of CBT originated and grew (Arnkoff & Glass, 1992; Beck, 2005; Dobson & Dozois, 2009; Thoma et al., 2015).

Some forms of CBT share characteristics of Beck's therapy, but their formulations and emphases in treatment vary to some degree. These include rational emotional behavior therapy (Ellis, 1962), dialectical behavior therapy (Linehan, 1993), problem-solving therapy (D'Zurilla &

Nezu, 2006), acceptance and commitment therapy (Hayes et al., 1999), exposure therapy (Foa & Rothbaum, 1998), cognitive processing therapy (Resick & Schnicke, 1993), cognitive behavioral analysis system of psychotherapy (McCullough, 1999), behavioral activation (Lewinsohn et al., 1980; Martell et al., 2001), cognitive behavior modification (Meichenbaum, 1977), and others. The form of CBT derived from Beck's model often incorporates techniques from all these therapies, as well as other evidence-based psychotherapies, within a cognitive framework. As time goes on, it will be useful for you to learn more about other evidence-based interventions. But it would be overwhelming to do so in any depth while you are still learning CBT. I would encourage you to master the basics of CBT first and then learn additional techniques to implement within the framework of a cognitive conceptualization.

CBT has been adapted for clients with diverse levels of education and income as well as a variety of cultures and ages, from young children to older adults. It is now used in hospitals and clinics, schools, vocational programs, prisons, and many other settings. It is used in group, couple, and family formats. While the treatment described in this book focuses on individual 45- to 50-minute sessions with outpatients, therapeutic interactions can be briefer. Full sessions are inappropriate for some clients, such as individuals who are hospitalized for treatment of severe schizophrenia. And many different health care and allied health care providers use CBT techniques, without conducting full therapy sessions, within brief medical or rehabilitation appointments or medication checks. Paraprofessionals and peer specialists, too, use appropriately adapted CBT techniques.

THE CBT THEORETICAL MODEL

In a nutshell, the *cognitive model* proposes that dysfunctional thinking (which influences the client's mood and behavior) is common to all psychological disturbances. When people learn to evaluate their thinking in a more realistic and adaptive way, they experience a decrease in negative emotion and maladaptive behavior. For example, if you were quite depressed and had difficulty concentrating and paying your bills, you

might have an *automatic thought*, an idea (in words or images) that just seemed to pop up in your mind: “I can’t do anything right.” This thought then leads to a particular reaction: You might feel sad (emotion) and retreat to bed (behavior).

In traditional CBT, your therapist would likely help you examine the *validity* of this thought, and you might conclude that you had overgeneralized and, in fact, you still do many things well, despite your depression. Looking at your experience from this new perspective would probably decrease your dysphoria and you might engage in more functional behavior (start paying bills). In a recovery-oriented approach, your therapist would help you evaluate your automatic thoughts. But the focus would be less on cognitions that have already arisen and more on cognitions that are likely to arise in the coming week that could interfere with your taking steps to achieve a specific goal.

Cognitions (both adaptive and maladaptive) occur at three levels. Automatic thoughts (e.g., “I’m too tired to do anything”) are at the most superficial level. You also have intermediate beliefs, such as underlying assumptions (e.g., “If I try to initiate relationships, I’ll get rejected”). At the deepest level are your core beliefs about yourself, others, and the world (e.g., “I’m helpless”; “Other people will hurt me”; “The world is dangerous”). For lasting improvement in clients’ mood and behavior, you will work at all three levels. Modifying both automatic thoughts and underlying dysfunctional beliefs produces enduring change.

For example, let’s say you continually underestimate your abilities. If so, you might have a core belief of incompetence. Modifying this general belief (i.e., seeing yourself in a more realistic light) can alter your perception of specific situations that you encounter daily. You will no longer have as many thoughts with the theme of incompetence. Instead, in specific situations where you make mistakes, you will probably think, “I’m not good at this [specific task].” In addition, it’s important in a recovery orientation to cultivate realistically positive automatic thoughts (e.g., “I can do a lot of things well”) and intermediate and core beliefs (e.g., “If I persevere, I can probably learn what I need to” and “I have strengths and weaknesses like everyone else”).

CBT RESEARCH

CBT has been extensively tested since the first outcome study was published in 1977 (Rush et al., 1977). At this point, more than 2,000 outcome studies have demonstrated the efficacy of CBT for a wide range of psychiatric disorders, psychological problems, and medical problems with psychological components. Many studies have also shown that CBT helps prevent or reduce the severity of future episodes. A study by von Brachel and colleagues (2019), for example, showed that outpatients with a range of psychiatric disorders who were treated with CBT in routine care continued to improve between 5 and 20 years after the end of therapy, more so than those who received medical treatment. (For meta-analyses and reviews of CBT, see Butler et al., 2006; Carpenter et al., 2018; Chambless & Ollendick, 2001; Dobson et al., 2008; Dutra et al., 2008; Fairburn et al., 2015; Hanrahan et al., 2013; Hofmann et al., 2012; Hollon et al., 2014; Linardon et al., 2017; Magill & Ray, 2009; Matusiewicz et al., 2010; Mayo-Wilson et al., 2014; Öst et al., 2015; and Wuthrich & Rapee, 2013. (For lists of conditions for which CBT has been shown to be effective, see *www.div12.org/psychological-treatments/treatments* and *www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines*. For research on CT-R, see Beck et al., in press; Grant et al., 2012, 2017.)

THE DEVELOPMENT OF BECK'S CBT

In the late 1950s, Dr. Beck was a certified psychoanalyst; his clients free-associated on a couch while he made interpretations. Beck recognized that the concepts of psychoanalysis needed to be experimentally validated if this school of psychotherapy were to be taken seriously by scientists. In the early 1960s, Beck decided to test the psychoanalytic concept that depression is the result of hostility turned inward toward the self.

He investigated the dreams of depressed clients, which, he predicted, would manifest greater themes of hostility than the dreams of psychiatric clients without depression. To his surprise, he ultimately found that the

dreams of depressed clients contained *fewer* themes of hostility and far greater themes of defectiveness, deprivation, and loss. He recognized that these themes paralleled his clients' thinking when they were awake. The results of other studies Beck conducted led him to believe that a related psychoanalytic idea—that depressed clients have a need to suffer—might be inaccurate (Beck, 1967). At that point, it was almost as if a stacked row of dominoes began to fall. If these psychoanalytic concepts weren't valid, how else could depression be understood?

As Dr. Beck listened to his clients on the couch, he realized that they occasionally reported two types of thinking: a free-association stream and a stream of quick, evaluative thoughts, especially about themselves. One woman, for example, detailed her sexual exploits. At the end of the session, she spontaneously reported that she had been feeling anxious. Dr. Beck made an interpretation: "You thought I was criticizing you." The client disagreed: "No, I was afraid I was *boring* you." When he questioned his other depressed clients, Dr. Beck recognized that all of them experienced "automatic" negative thoughts that were closely tied to their emotions. He began to help his clients identify, evaluate, and respond to their unrealistic and maladaptive thinking. When he did so, they rapidly improved.

Dr. Beck then began to teach his psychiatric residents at the University of Pennsylvania to use this form of treatment. They, too, found that their clients responded well. The chief resident, A. John Rush, MD, who became a leading authority in the field of depression, discussed conducting an outcome trial with Dr. Beck. They agreed that such a study was necessary to demonstrate the efficacy of cognitive therapy. Their randomized controlled study of depressed clients, published in 1977, established that cognitive therapy was as effective as imipramine, a common antidepressant. This was an astounding study. It was one of the first times that a talk therapy had been compared to a medication. In a follow-up study, cognitive therapy was shown to be much more effective than imipramine in preventing relapse. Beck and colleagues (1979) published the first cognitive therapy treatment manual 2 years later.

Starting in the late 1970s, Dr. Beck and his postdoctoral fellows at the University of Pennsylvania began to study anxiety, substance use, personality disorders, couples' problems, hostility, bipolar disorder, and other conditions, using the same process. First, they made clinical

observations about the disorder; they outlined the maintaining factors and key cognitions (thoughts and underlying beliefs, emotions, and behaviors). Then they tested their theories, adapted treatment, and undertook randomized controlled trials. Fast-forward several decades. Dr. Beck and I and researchers worldwide continue to study, theorize, adapt, and test treatments for clients who suffer from an ever-growing list of problems. CBT is now taught in most graduate schools in the United States and in many other countries. It is the most broadly practiced therapy in the world (David et al., 2018; Knapp et al., 2015).

RECOVERY-ORIENTED COGNITIVE THERAPY

In recent decades, there has been an innovation in the field of mental health: the recovery movement, which was started as an alternative approach to the medical model for individuals diagnosed with a serious mental health condition. Aaron Beck, our colleagues at the Beck Institute for Cognitive Behavior Therapy, and I are now refining recovery-oriented cognitive therapy (CT-R) for individuals diagnosed with a wide range of conditions. CT-R, an adaptation of traditional CBT, maintains the theoretical foundation of the cognitive model in conceptualizing individuals and planning and delivering treatment. But it adds an additional emphasis on the cognitive formulation of clients' *adaptive* beliefs and behavioral strategies, and factors that maintain a positive mood. Rather than emphasizing symptoms and psychopathology, CT-R emphasizes clients' strengths, personal qualities, skills, and resources.

Taking a recovery orientation, I elicited and conceptualized Abe's aspirations and values to plan treatment. Family, for example, was very important to Abe, and despite his deep depression, he was willing to push himself to increase his interaction with them. We set up many potentially rewarding activities for Abe to engage in between sessions *and helped him draw positive conclusions about these experiences*. We cultivated positive cognitions and memories and used the therapeutic relationship and a variety of techniques to strengthen an adaptive core belief about the self and to experience positive emotion in and out of session.

One difference between traditional CBT and CT-R is the time orientation. In traditional CBT we tend to talk about problems that arose in the past week and use CBT techniques to address them. In CT-R, we focus more on clients' aspirations for the future, their values, and steps they can take each week toward their goals. The usual CBT techniques are used in overcoming challenges or obstacles clients will face in taking these steps.

A TYPICAL COGNITIVE INTERVENTION

Below is an excerpt from a therapy session with Abe. It provides the flavor of a typical CBT intervention. First, we agree to talk about a goal Abe wants to work on. We discuss steps he can take and the obstacles that could get in the way.

JUDITH: Okay, did you want to start by talking about your goal to get a job?
ABE: Yeah, I really need the money.
JUDITH: What's one step you'd like to take this coming week?
ABE: (*Sighs.*) I guess I should update my résumé.
JUDITH: That's important. [starting problem solving] How will you go about doing that?
ABE: I don't know. I haven't even looked at it in years.
JUDITH: Do you know where it is?
ABE: Yeah. But I'm not sure what to put on it.
JUDITH: What are some ways you could figure this out?
ABE: I guess I could go online. But my concentration hasn't been too good lately.
JUDITH: Would you be better off talking to someone who knows more about résumés than you do?
ABE: Yeah. (*Thinks.*) I could talk to my son.
JUDITH: What would you think about calling him today? Could anything get in the way?
ABE: I don't know. I should be able to figure out what to do myself, without bothering him.
JUDITH: That's an interesting idea—that you should be able to figure it out. Have you had a lot of experience looking at other people's résumés?

ABE: No, I don't know that I ever saw one from someone else.
JUDITH: How much bother do you think it would be for your son?
ABE: Not that much, I guess.
JUDITH: So, what would be good to remind yourself before you call him?
ABE: That he's had much more recent experience with résumés than I've had. That he'd probably be okay with helping me.
JUDITH: (*Praising Abe*.) That's excellent. Could you call him today?
ABE: Tonight would be better.

Abe was easily able to identify and respond to an unhelpful thought that could have posed an obstacle to taking a step toward achieving a valued goal. I asked him to imagine that, with his son's help, he had successfully revised his résumé. Then I asked him how he felt emotionally in the image and helped him experience some of the positive feeling right in our session. (Some clients, facing a similar problem, might require a greater therapeutic effort before they're able to follow through behaviorally.)

BECOMING AN EFFECTIVE CBT THERAPIST

I hope you have an aspiration to become an excellent therapist and help hundreds or thousands of individuals in your career. Keeping this aspiration in mind can help you persevere if you become anxious while reading this book. If you do feel nervous, remember that the cognitive model proposes you've had some negative thoughts. You'll be learning tools throughout the book to address these kinds of unhelpful thoughts. Meanwhile, it helps to think about a specific reading goal each week and the obstacles you might face in taking the steps you need to. And make sure your expectations for yourself are reasonable.

I'd like you to know that I wasn't a very good therapist when I first began doing CBT. How could it have been any different? I had never done therapy before. So, give yourself a break if you're just starting out or if you're fairly new to CBT. You're in good company. Recognize and give yourself credit for each chapter you read. Also give yourself credit for answering the reflection questions and doing the practice exercises you'll

find at the end of each chapter. Compare yourself to your peers, not to expert CBT therapists.

We often use analogies and metaphors in CBT (Stott et al., 2010). Here's a common one we use with clients that you may find useful yourself.

> "Do you remember learning how to drive or to play a musical instrument? At first, did you feel a little awkward? Did you have to pay a great deal of attention to small details and motions that now come smoothly and automatically to you? Did you ever feel discouraged? As you progressed, did the process make more and more sense and feel more and more comfortable? Did you finally master it to the point where you were able to perform the task with relative ease and confidence? Most people have had just such an experience learning a skill in which they are now proficient."

The learning process is the same for the beginning CBT therapist. Keep your goals small, well defined, and realistic. Compare your progress to your ability level before you started reading this book or to the time you first started learning about CBT. Be careful not to undermine your confidence by contrasting your current level of skill with your ultimate objective.

If you feel anxious about starting to use CBT with clients, make yourself a "coping card," a physical or virtual index card on which you have written statements that are important to remember. You'll be using coping cards or their equivalents with your clients (because we make sure that anything we want clients to remember is written down). My psychiatric residents often have unhelpful thoughts before they see their first outpatients. After a discussion, they create a card that addresses these thoughts. The card is individualized but generally says something such as follows:

My goal is not to cure this client today. No one expects me to.
My goal is to establish a good relationship, to inspire hope, to identify what's really important to the client, and perhaps to figure out a step the client can take this week toward achieving his or her goals.

Reading a card like this can help you reduce your anxiety so you can focus on your clients and be more effective.

To the untrained observer, CBT sometimes appears deceptively simple. The *cognitive model*, the proposition that one's thoughts influence one's emotions and behavior (and sometimes physiology), is quite straightforward. Experienced CBT therapists, however, seamlessly accomplish many tasks at once: building rapport, socializing and educating the client, collecting data, conceptualizing the case, working toward clients' goals and overcoming obstacles, teaching skills, summarizing, and eliciting feedback. As they're accomplishing these tasks, they sound almost conversational.

If you're new to the field, you will need to be more deliberate and structured, concentrating on fewer elements at one time. Although the ultimate goal is to interweave these elements and conduct therapy as effectively and efficiently as possible, you first need to learn skills to develop the therapeutic relationship and to conceptualize clients. You'll also learn the techniques of CBT (and other modalities), all of which is best done in a step-by-step manner.

You can view the development of expertise as a CBT therapist in four stages. (These descriptions assume that you are already proficient in basic counseling skills: listening, empathy, concern, positive regard, and genuineness, as well as accurate understanding, reflection, and summarizing.) In Stage 1, you learn basic skills of conceptualizing a case in cognitive terms based on an intake evaluation and data collected in session. You learn how to develop a strong therapeutic relationship. You learn how to structure the session and use your conceptualization of the client and good common sense to plan treatment, considering your clients' values, aspirations, and goals. You help clients develop solutions to the obstacles they face and view their dysfunctional thoughts in a different

way. You learn to use basic cognitive and behavioral techniques and to teach your clients how to use them.

In Stage 2 you become more proficient at integrating your conceptualization with your knowledge of techniques. You strengthen your ability to understand the flow of therapy. You become more easily able to identify critical objectives of treatment and more skillful at conceptualizing clients, refining your conceptualization, and using the conceptualization to make moment-to-moment decisions about interventions. You expand your repertoire of strategies and become more proficient in selecting, timing, and implementing appropriate techniques and in strengthening the therapeutic relationship.

In Stage 3 you more automatically integrate new data into the conceptualization. You refine your ability to make hypotheses to confirm or revise your view of the client. You vary the structure and techniques of basic CBT as appropriate, particularly for clients with personality disorders and other difficult disorders and problems. You become more skilled at preventing and also repairing ruptures in the therapeutic alliance.

In Stage 4 you continue learning CBT for the rest of your professional life. I keep learning from every client I treat. I participate in weekly case conferences, consult on clinical matters with colleagues and supervisees, and stay current with CBT research and practice by reading books and articles and regularly attending conferences. I'm a much better therapist today than I was 5 years ago. And I hope to be a better therapist 5 years from now. I hope you will adopt a similar attitude about the importance of lifelong learning.

If you already practice in another psychotherapeutic modality but are new to CBT, you will likely be more effective if you start implementing it with new clients. If you decide to implement it with existing clients, it will be important for you to do so collaboratively. You should describe what you would like to do differently, provide a rationale, and seek the client's agreement. Most clients agree to such changes when they are phrased positively, to the client's benefit. When clients are hesitant, you can suggest a change (such as setting an agenda) as an "experiment," rather than a commitment, to motivate them to try it.

THERAPIST: I was reading an important book on making therapy more effective and I thought of you.

CLIENT: Oh?

THERAPIST: Yes, and I have some ideas about how you might be able to feel better faster. [being collaborative] Is it okay if I tell you about it?

CLIENT: Okay.

THERAPIST: One thing I read was called "setting the agenda." That means at the beginning of sessions, I'd like to ask you which goals or issues you want to work on in the session. For example, you might say that you'd like to work on socializing more or getting more done around the house. This will help us figure out how to spend our time in session better. (*pause*) How does that sound?

MAKING THE BEST USE OF THIS BOOK

This book is intended for students and clinicians at any stage of experience and skill development who lack mastery in the fundamental building blocks of cognitive conceptualization and treatment—or who want to learn how to incorporate principles of CT-R into treatment. It's critical to master the basic elements of CBT (and CT-R) so you can understand how and when to vary standard treatment for individual clients.

The chapters of this book are designed to be read in the order presented. You might be eager to skip over introductory chapters and jump to the "how-to" chapters. The sum of CBT, however, is not merely the use of cognitive and behavioral techniques. Among other attributes, it entails the artful selection and effective use of many different kinds of interventions based on your conceptualization of the client. Visit *beckinstitute.org/CBTresources* to find videos of Abe's treatment and downloadable worksheets. You'll find a list of additional CBT resources in Appendix A.

A note about worksheets: You'll need to print out some worksheets, such as the Thought Record and the Testing Your Thoughts Worksheet (from Chapter 15), because they contain a great amount of information. And you may need to print out additional worksheets when you're first starting to use CBT. But once you become familiar with the material, it's

often preferable to hand draw worksheets as you sit in the session with a client. Doing this allows you to individualize them as necessary, and you are more likely to avoid a negative reaction from clients who don't like formal worksheets.

Your growth as a CBT therapist will be enhanced if you start applying what you learn to yourself. Make sure to do all the practice exercises. For example, in the practice exercise at the end of this chapter, you'll be directed to identify your own automatic thoughts as you read this book. You can note them and refocus on your reading. Or after identifying them, you could use the questions on the next page to create a coping card for yourself. By turning the spotlight on your own thinking, you can boost your CBT skills, modify your dysfunctional thoughts, and positively influence your mood (and behavior), making you more receptive to learning.

Other practice exercises ask you to role-play with a peer, friend, colleague, or family member. If you can't find a role-play partner, you can write a transcript with an imaginary client. Or you might do both. The more you practice the vocabulary and concepts of CBT, the better your treatment will be.

Teaching yourself the basic skills of CBT using yourself as the subject will enhance your ability to teach your clients these same skills. As an added bonus, when you use skills that are helpful, you can do some relevant self-disclosure with clients—which can encourage them to practice the skill too. An online course also provides you with many opportunities to practice using CBT skills on yourself; it's one of the best ways to really grasp and practice this kind of therapy.

It's also important for you to know what this book doesn't cover. Its focus is depression, and important variations are needed to treat other disorders. It doesn't include how to adapt treatment for youth or older adults. And it doesn't address the very important topics of self-harm, substance use, suicidality, or homicidality. You will need to supplement your learning to be effective with individuals who vary substantially from our major client example, Abe.

SUMMARY

CBT was developed by Dr. Aaron Beck in the 1960s and 1970s and has since been demonstrated to be effective in more than 2,000 published outcome studies. Today, it is considered the "gold standard" of psychotherapy (David et al., 2018). It's based on the theory that people's thinking influences their emotions and behavior. By helping their clients evaluate and change dysfunctional or unhelpful thinking, CBT therapists can bring about lasting change in mood and behavior. CBT therapists employ techniques from many different psychotherapeutic modalities, applied within the context of the cognitive model and of their individualized conceptualizations of their clients. A recovery orientation focus has recently been added to traditional CBT, emphasizing values and aspirations, drawing positive conclusions from their day-to-day activities, and experiencing positive emotion in and outside of the therapy session.

REFLECTION QUESTIONS

What new ideas have you learned about CBT or CT-R in this chapter? How could CBT techniques help you? What thoughts could readers have that would deter them from applying CBT skills to themselves? What would be good responses to those thoughts?

PRACTICE EXERCISE

As of right now, start noticing when

- your mood has changed or intensified in a negative direction,
- you are having bodily sensations associated with negative emotion (such as your heart beating fast when you become anxious), and/or
- you are engaging in unhelpful behavior or avoiding engaging in helpful behavior.

Ask yourself what emotion you are experiencing, as well as the cardinal question of cognitive therapy:

> "What was just going through my mind?"

This is how you'll teach yourself to identify your own automatic thoughts. Pay particular attention to automatic thoughts that get in the way of achieving your goals, especially the ones

that interfere with reading this book and trying techniques with clients. You may recognize thoughts such as these:

"This is too hard."
"I may not be able to master this."
"This doesn't feel comfortable to me."
"What if I try it and it doesn't help my client?"

Experienced therapists whose primary orientation has not been CBT may be aware of a different set of automatic thoughts:

"This won't work."
"The client won't like it."
"It's too superficial/structured/unempathic/simple."

---

[1] I've changed his name and some identifying characteristics.

[2] I've changed her name and some identifying characteristics.

2

OVERVIEW OF TREATMENT

In this chapter, you'll read about CBT principles of treatment. While CBT is individualized for each person, there are certain commonalities that apply to most clients. But don't worry about remembering everything in this chapter because you'll be exposed to all the concepts at various points throughout the book. I just want you to have a sense of what CBT is like. You may want to watch a full therapy session and use the Principles of Treatment Checklist (you'll find both at *beckinstitute.org/CBTresources*) to note which principles below are illustrated in the video.

PRINCIPLES OF TREATMENT

1. CBT treatment plans are based on an ever-evolving cognitive conceptualization.
2. CBT requires a sound therapeutic relationship.
3. CBT continually monitors client progress.
4. CBT is culturally adapted and tailors treatment to the individual.
5. CBT emphasizes the positive.
6. CBT stresses collaboration and active participation.
7. CBT is aspirational, values based, and goal oriented.
8. CBT initially emphasizes the present.
9. CBT is educative.
10. CBT is time sensitive.
11. CBT sessions are structured.
12. CBT uses guided discovery and teaches clients to respond to their dysfunctional cognitions.
13. CBT includes Action Plans (therapy homework).
14. CBT uses a variety of techniques to change thinking, mood, and behavior.

Principle 1: CBT treatment plans are based on an ever-evolving cognitive conceptualization. I base my conceptualization of clients on the data they provide at the evaluation, informed by the cognitive formulation (key cognitions, behavioral strategies, and maintaining factors that characterize their disorder[s]). From the beginning, I incorporate their strengths, positive qualities, and resources into my conceptualization too. I continue to refine this conceptualization throughout therapy as I collect additional data, and I use the conceptualization to plan treatment.

My treatment plan for Abe initially focused on current cognitions and problematic behaviors that interfered with working toward his goals. We discussed increasing action in line with Abe's values and aspirations, and he began monitoring his positive experiences. Toward the middle of therapy, we added a focus on underlying beliefs that undermined his confidence. At the end of treatment, we added an emphasis on planning for the future, anticipating obstacles, and developing a plan to overcome these obstacles. We also responded to maladaptive cognitions about termination and focused on cognitions and behaviors that are important for relapse prevention.

I conceptualize Abe's difficulties in three time frames. From the beginning, I identify current cognitions that are obstacles to his aspirations ("I'm a failure"; "I can't do anything right"). I also identify *behavioral obstacles* that serve to maintain his depression (isolating himself, inactivity). Second, I identify *precipitating factors* that influenced Abe's perceptions at the onset of his depression. He struggled at work and then lost his job; his wife became increasingly critical and divorced him. These events led to his belief that he was incompetent. Third, I hypothesize about the key *developmental events* and his *enduring patterns of interpreting* these kinds of events that may have predisposed him to depression. As a preteen, Abe's mother expected him to take on significant responsibilities at home, for which he was developmentally ill equipped. Rather than seeing that his overwhelmed mother was expecting too much of him, he interpreted her criticism as valid.

Principle 2: CBT requires a sound therapeutic relationship. Clients vary in the degree to which they are initially able to develop a good therapeutic alliance. It wasn't difficult to establish the relationship with

Abe, though initially he was skeptical that I could help him. Using good Rogerian counseling skills, asking him for his reaction to the treatment plan, making collaborative decisions about treatment, providing rationales for interventions, using self-disclosure, eliciting feedback during and at the end of sessions, and working hard to achieve (and have him recognize) progress contributed to our alliance.

In general, you spend enough time developing the therapeutic relationship to engage clients in working effectively with you as a team. You use the relationship to provide evidence that clients' negative beliefs, especially beliefs about the self (and sometimes about others), are inaccurate and that more positive beliefs are valid. If the alliance is sound, you can maximize the time you spend helping clients resolve obstacles they will face in the coming week. Some clients, particularly those with personality disorders, do require a far greater emphasis on the therapeutic relationship and advanced strategies to forge a good working alliance (J. S. Beck, 2005; Beck et al., 2015; Young, 1999).

Principle 3: CBT continually monitors client progress. The earliest CBT treatment manual, *Cognitive Therapy of Depression* (Beck et al., 1979), advised therapists to use weekly symptom checklists and to elicit both verbal and written feedback from clients at the end of sessions. Various studies have since demonstrated that routine monitoring improves outcomes (Boswell et al., 2015; Lambert et al., 2001, 2002; Weck et al., 2017). Client outcomes are enhanced when both clients and therapists receive feedback on how clients are progressing. With an increased emphasis on a recovery orientation, many CBT therapists now also measure clients' general functioning, progress toward their goals, and sense of satisfaction, connection, and well-being.

Principle 4: CBT is culturally adapted and tailors treatment to the individual. CBT has traditionally reflected the values of the dominant culture in the United States. Clients with different ethnic and cultural backgrounds, though, have better outcomes when their therapists appreciate the significance of cultural and ethnic differences, preferences, and practices (Beck, 2016; Smith et al., 2011; Sue et al., 2009). CBT tends to emphasize rationality, the scientific method, and individualism. Clients from other cultures may hold different values and preferences: for

example, emotional reasoning, varying degrees of emotional expression, and collectivism or interdependence.

When clients' cultures are different from your own, you may need to improve your cultural competency. You may, in fact, be largely unaware of your own cultural biases. You may also be unaware of the extent of cultural bias some clients experience in their community, especially if they are not part of the majority culture. Such biases and prejudice may play a significant role in your clients' difficulties.

Your clients may differ from you in many ways, in addition to culture. These include age, religious or spiritual orientation, ethnicity, socioeconomic status, disability, gender, sexual identity, and sexual orientation (Iwamasa & Hays, 2019). Make sure to educate yourself about your clients' characteristics and anticipate how these differences might be relevant to treatment. Hays (2009) describes strategies to make CBT culturally responsive, including assessing the client's and family's needs, emphasizing culturally respectful behavior, identifying culturally related strengths and supports, and validating clients' experiences of oppression. Of course, you still need to conceptualize the individual client and refrain from *assuming* that you'll need to vary treatment for a given individual.

Principle 5: CBT emphasizes the positive. Recent research demonstrates the importance of emphasizing positive emotion and cognition in treating depression (see, e.g., Chaves et al., 2019). You help clients actively work toward cultivating positive moods and thinking. It is also very important to inspire hope.

Abe was like most depressed clients. He tended to focus on the negative. When he was in the depressive mode, he automatically (i.e., without conscious awareness) and selectively attended to negative experiences. He also misread neutral experiences as negative at times. In addition, he often discounted or failed to recognize more positive experiences. His difficulty in processing positive data in a straightforward manner led him to develop a distorted sense of himself. To counteract this feature of depression, you continually help clients attend to the positive. I want Abe to start engaging in experiences in which he concludes he is a resourceful person who can solve problems, overcome obstacles, and lead a satisfying life.

Principle 6: CBT stresses collaboration and active participation. Both therapists and clients are active. I encourage Abe to view therapy as teamwork; together we decide what to work on each session, how often we should meet, and what Abe can do between sessions. At first, I'm more active in suggesting a direction for therapy sessions and for some Action Plans (therapy homework). As Abe becomes less depressed and more socialized to treatment, I encourage him to become increasingly active in the session: deciding which steps to take toward his goals, problem solving potential obstacles, evaluating his dysfunctional cognitions, summarizing important points, and devising Action Plans.

Principle 7: CBT is aspirational, values based, and goal oriented. In your initial session with clients, you should ask them about their values (what is really important to them in life), their aspirations (how they want to be, how they want their life to be), and their specific goals for treatment (what they want to accomplish as a result of therapy). Being responsible, competent, productive, and helpful to others were important values for Abe. He aspired to have a better life, to regain his sense of optimism and well-being, and to feel in control. His specific goals included being a better father and grandfather and getting a good job. But thoughts such as "I'm such a failure" and "I'll never get a job" were obstacles. They had contributed to his avoiding steps he needed to take to reach his goals.

Principle 8: CBT initially emphasizes the present. The treatment of most clients involves a strong focus on the skills they need to improve their mood (and their lives). Clients who use these skills consistently (during and after treatment) have better outcomes than those who don't, even in the face of significant stressful life events (Vittengl et al., 2019). When Abe viewed distressing situations more realistically, solved problems, and worked toward his goals, he felt less depressed. His mood became more positive as he focused his attention on what was going well in his life and what admirable qualities those experiences indicated about him as a person.

You shift the focus to the past in three circumstances:

1. When the client expresses a strong desire to do so,
2. When work directed toward current problems and future aspirations produces insufficient change, or

3. When you judge that it's important for you and clients to understand how and when their key dysfunctional ideas and behavioral coping strategies originated and became maintained.

Afterward, you'll discuss what your clients now understand about the past and how they can make use of their new understanding in the coming week.

For example, midway through treatment, Abe and I briefly discussed some childhood events to help him identify a belief he learned as a child: "If I ask for help, people will see how incompetent I am." I helped Abe evaluate the validity of this belief in both the past and the present. Doing so led him, in part, to develop a more functional, more reasonable belief. If he had had a personality disorder, I may have spent proportionally more time discussing his developmental history and childhood origin of beliefs and coping behaviors.

Principle 9: CBT is educative. A major goal of treatment is to make the process of therapy understandable. Abe felt more comfortable once he knew what to expect from treatment, when he clearly understood what I wanted him to do, when he felt as if he and I were a team, and when he had a concrete idea of how therapy would proceed, both within a session and over the course of treatment. In our first session, I educated Abe about the nature and course of his disorder, the process of CBT, the structure of sessions, and the cognitive model. I provided him with additional psychoeducation in future sessions, presenting my ongoing and refined conceptualization and asking him for feedback. I used diagrams throughout treatment to help Abe understand why he sometimes had distorted thoughts and maladaptive reactions. (See Boisvert & Ahmed [2018] for many kinds of diagrams that are helpful in educating clients.)

Throughout treatment, after using various techniques, I taught Abe how to use the techniques himself, so he could learn to be his own therapist. At each session, I encouraged Abe to record the most important ideas he had learned so he could review his new understandings daily. Abe also occasionally reviewed these notes after termination, when he found himself slipping back into old patterns of thinking and behavior.

Principle 10: CBT is time sensitive. We used to say that CBT was a short-term therapy. Many straightforward clients with depression and

anxiety disorders require between 6 and 16 sessions. But the treatment for some conditions needs to be much longer. We try to make treatment as short term as possible while still fulfilling our objectives: to help clients recover from their disorder(s); work toward fulfilling their aspirations, values, and goals; resolve their most pressing issues; promote satisfaction and enjoyment in life; and learn skills to promote resilience and avoid relapse.

Abe initially had weekly therapy sessions. (Had his depression been more severe or had he been suicidal, I may have arranged more frequent sessions.) After 2½ months, Abe was feeling somewhat better and was able to use his skills between sessions. So, we collaboratively decided to experiment with every other week and then monthly sessions. Even after termination, we planned periodic "booster" sessions every 3 months for a year.

Some clients need considerably more treatment over a longer period of time. Sometimes these clients have chaotic lives or face ongoing severe challenges such as poverty or violence. Some have chronic or treatment-resistant disorders. Others have personality disorders, entrenched substance use, bipolar disorder, eating disorders, or schizophrenia. A year or even two of therapy may be insufficient. Even after termination, they may need periodic sessions or additional (usually shorter) courses of treatment.

Principle 11: CBT sessions are structured. CBT therapists aim to conduct therapy as efficiently as possible to help clients feel better as quickly as possible. Adhering to a standard format (as well as teaching the therapeutic techniques to clients) facilitates these objectives. You will tend to use this format in every session (unless your client objects, in which case you may need to negotiate the structure initially).

I start planning Abe's treatment before he enters my office. I quickly review his chart, especially his goals for treatment and Action Plans (including therapy notes) from the previous session(s). My overarching therapeutic goal is to improve Abe's mood during the session and to create an Action Plan so he can feel better and behave more functionally during the week. What I do in any given session is influenced by Abe's goals and issues, my conceptualization, the strength of our therapeutic relationship, Abe's preferences, and the stage of treatment.

Your goal in the first part of a therapy session is to reestablish the therapeutic alliance, review the Action Plan, and collect data so you and the client can collaboratively set and prioritize the agenda. In the second part of the session, you and the client discuss the issues or goals on the agenda. These kinds of discussions and interventions naturally lead to Action Plans. In the final part of the session, you or the client summarizes the session. You make sure the Action Plan is reasonable and then elicit and respond to clients' feedback. While experienced CBT therapists may deviate from this format at times, novice therapists are usually more effective when they follow the specified structure.

Principle 12: CBT uses guided discovery and teaches clients to respond to their dysfunctional cognitions. In the context of discussing a problem or goal, you ask clients questions to help them identify their dysfunctional thinking (by asking what was going through their mind), evaluate the validity and utility of their thoughts (using a number of techniques), and devise a plan of action. With Abe, I use gentle *Socratic questioning*, which helps foster his sense that I am truly interested in *collaborative empiricism*, that is, helping him determine the accuracy and utility of his ideas through a careful review of the evidence. Note that we refrain from *challenging* cognitions (by stating or trying to convince clients that their thoughts or beliefs aren't valid); rather, we help clients through cognitive restructuring, a process of assessing and responding to maladaptive thinking.

In other sessions, I ask Abe about the *meaning* of his thoughts to uncover underlying beliefs he holds about himself, his world, and other people. Through questioning, I also guide him in evaluating the validity and functionality of his beliefs. And from the beginning of treatment, I help Abe fortify positive beliefs about himself by teaching him to give himself credit and guiding him to draw positive conclusions about the steps he has taken toward his goals.

Depending on the kind of cognition you've agreed to address, you might substitute or add additional techniques to those above. When automatic thoughts are part of a dysfunctional thought process such as rumination, obsession, or continual self-criticism, you might help clients accept their thoughts nonjudgmentally and allow them to come and go on their own. To change cognitions at the emotional or gut level, you might

use imagery, tell a story, offer analogies and metaphors, employ experiential techniques, do role-playing, or suggest behavioral experiments.

Principle 13: CBT includes Action Plans (therapy homework). An important aim of treatment is to help clients feel better by the end of the session and to set them up to have a better week. Action Plans usually consist of

- identifying and evaluating automatic thoughts that are obstacles to clients' goals,
- implementing solutions to problems and obstacles that could arise in the coming week, and/or
- practicing behavioral skills learned in session.

Clients tend to forget much of what occurs in therapy sessions, and when they do, they tend to have poorer outcomes (Lee et al., 2020). So here's our rule of thumb:

Anything we want clients to remember is recorded.

You or your client should write down therapy notes and Action Plans, either on paper or in the client's phone or tablet. Or you can record therapy notes on a cell phone by using an app. Here's an example of a therapy note that Abe and I collaboratively composed:

If I start to think that I can't sit down and pay bills, remind myself:
• *I'm only going to do it for 10 minutes.*
• *It may be difficult but probably won't be impossible.*
• *The first minute or two will probably be the hardest and then it's likely to get easier.*
• *I should focus on the positive feeling I will get from accomplishing something I haven't been able to do.*

Action Plans naturally flow from the discussion of each goal or issue on the agenda. You'll need to craft them carefully with clients, based on the nature of the issue, your conceptualization of what will help most, practical considerations (such as time, energy, and opportunity), and client variables (e.g., level of motivation and concentration, and preferences). A frequent mistake of therapists is suggesting Action Plans that are much too difficult.

Principle 14: CBT uses a variety of techniques to change thinking, mood, and behavior. In fact, we adapt strategies from many psychotherapeutic modalities within the context of the cognitive framework. For example, depending on my conceptualization of a client, I may use techniques from acceptance and commitment therapy, behavior therapy, compassion-focused psychotherapy, dialectical behavior therapy, Gestalt therapy, interpersonal psychotherapy, meta-cognitive therapy, mindfulness-based cognitive therapy, person-centered psychotherapy, psychodynamic psychotherapy, schema therapy, solution-based therapy, well-being therapy, or others. While you're still learning CBT, it will be difficult for you to incorporate a wider variety of interventions than the ones you'll read about in this book. I would encourage you to master the basics of CBT first and then learn additional techniques to implement within the framework of a cognitive conceptualization. As you progress as a CBT clinician, it will be worthwhile to study these and other evidence-based treatments.

SUMMARY

The basic principles described in this chapter apply to most clients. Guided by your cognitive conceptualization of each client, you will vary the techniques you use to tailor treatment to the individual. CBT treatment takes into account individuals' cultures, family history, and other important characteristics; the nature of their difficulties; their goals and

aspirations; their ability to form a strong therapeutic bond; their motivation to change; their previous experience with therapy; and their preferences. The foundation of treatment is always a solid therapeutic relationship.

REFLECTION QUESTIONS

Which of the 14 principles of treatment did you already know were important elements of CBT? Which were new? Did any of them surprise you?

PRACTICE EXERCISES

Review the principles of treatment. Describe in your own words why each is important. Then think about what else you'd like to know about each principle and compose a relevant question.

Consider watching an entire therapy session. Use the Principles of Treatment Checklist (*beckinstitute.org/CBTresources*) to note which principles are demonstrated in the video.

3

COGNITIVE CONCEPTUALIZATION

A cognitive conceptualization is the cornerstone of CBT. You'll be learning more about the various elements and the process of conceptualization throughout this book. In this chapter, you'll find the answers to the following questions:

- What is a cognitive conceptualization?
- How do you initiate the process of conceptualization?
- How do automatic thoughts help you understand clients' reactions?
- What are core beliefs and intermediate beliefs?
- What is a more complex cognitive model?
- What is Abe's conceptualization?
- How do you complete a Cognitive Conceptualization Diagram?

INTRODUCTION TO COGNITIVE CONCEPTUALIZATION

Your conceptualization provides the framework for treatment. It helps you

- understand clients, their strengths and weaknesses, their aspirations and challenges;
- recognize how it is that clients developed a psychological disorder with dysfunctional thinking and maladaptive behavior;
- strengthen the therapeutic relationship;
- plan treatment within and across sessions;
- select appropriate interventions and adapt treatment as needed; and
- overcome stuck points.

An organic, evolving formulation helps you plan for efficient and effective therapy (Kuyken et al., 2009; Needleman, 1999; Persons, 2008; Tarrier, 2006). You begin to construct the conceptualization during your first contact with a client and refine it at every subsequent contact. It's important to understand the cognitive formulation for the client's diagnosis(es), the typical cognitions, behavioral strategies, and maintaining factors. But then you need to see whether the formulation fits your specific client. You continually collect data, summarize what you've heard, check out your hypotheses with the client, and modify your conceptualization as needed. For example, I didn't know in the first few sessions that Maria had a belief of worthlessness. It wasn't until she had a shouting match with her mother and sister that this belief came to light.

You confirm, disconfirm, or modify your hypotheses as clients present new information. You continually ask yourself, "Is the new data I've just learned part of a pattern I've already identified—or is it something new?" If new, make a note to check in future sessions to see if these data are part of another pattern.

You share your conceptualization and ask the client whether it "rings true" or "seems right." If your conceptualization is accurate, the client invariably says something like "Yes, I think that's right." If you're wrong, the client usually says, "No, it's not exactly like that. It's more like _____." Eliciting the client's feedback strengthens the alliance and allows you to more accurately conceptualize and conduct effective treatment. In fact, sharing your conceptualization can itself be therapeutic (Ezzamel et al., 2015; Johnstone et al., 2011). Abe felt better when I suggested that he really had only one problem: seeing himself as incompetent and a failure.

> "I think you believe this so strongly that you avoid doing things that seem hard. And when you're depressed, almost *everything* seems hard. (*pause*) Do you think I could be right?"

It's important to put yourself in your clients' shoes, to develop empathy for what they are experiencing, to understand how they are feeling, and to perceive the world through their eyes. Clients' perceptions, thoughts, emotions, and behavior should make sense given their interpretation of past and current experiences, their strengths and vulnerabilities, their values and personal attributes, their biology, and their genetics and epigenetics.

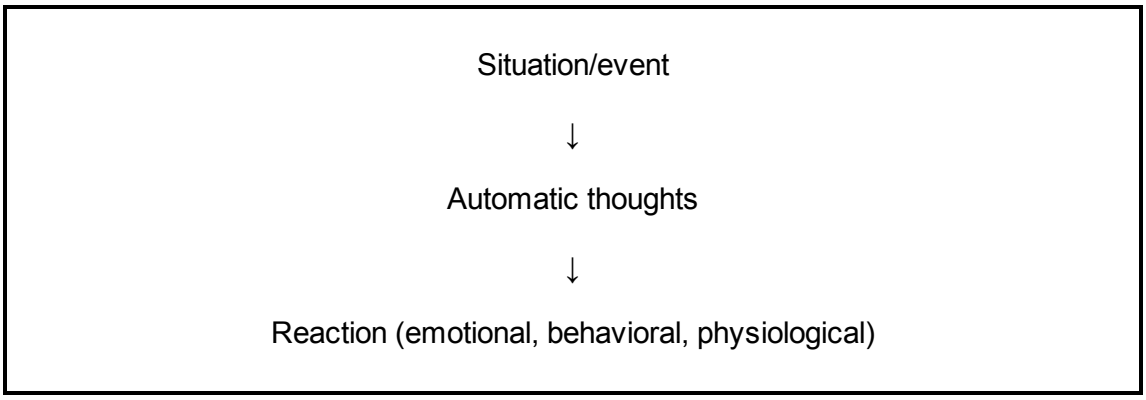
Your conceptualization also helps you understand and build on your clients' positive attributes and skills. Helping clients become more aware of their strengths and resources can lead to better functioning and improved mood and resilience (Kuyken et al., 2009). It also helps you understand how and why obstacles to achieving their goals have arisen and been maintained.

INITIATING THE PROCESS OF CONCEPTUALIZATION

There are many questions you should keep in mind throughout treatment to develop and refine your conceptualization. See Chapter 5 for a description of the evaluation session, in which you'll start to collect a great deal of information: clients' identifying information; chief complaint, major symptoms, mental status, and diagnosis; current psychiatric medications and concurrent treatment; significant relationships; best lifetime functioning; and various aspects of their history. You'll continue to gather data throughout treatment.

AUTOMATIC THOUGHTS HELP EXPLAIN CLIENTS' REACTIONS

CBT is based on the *cognitive model*, which hypothesizes that people's emotions, behaviors, and physiology are influenced by their perception of events (both external, such as failing a test, and internal, such as distressing physical symptoms).



It's not a situation in and of itself that determines what people feel and do but rather how individuals *construe* a situation (Beck, 1964; Ellis, 1962). Imagine, for example, a situation in which several people are reading a basic text on CBT. They have quite different emotional and behavioral responses to the same situation, based on what is going through their minds as they read.

- Reader A thinks, "This really makes sense. Finally, a book that will really teach me to be a good therapist!" Reader A feels mildly excited and keeps reading.
- Reader B, on the other hand, thinks, "This approach is too simplistic. It will never work." Reader B feels disappointed and closes the book.
- Reader C has the following thoughts: "This book isn't what I expected. What a waste of money." Reader C is disgusted and discards the book altogether.
- Reader D thinks, "I really need to learn all this. What if I don't understand it? What if I never get good at it?" Reader D feels anxious and keeps reading the same few pages over and over.
- Reader E has different thoughts: "This is just too hard. I'm so dumb. I'll never master this. I'll never make it as a therapist." Reader E feels sad and turns on the television.

The way people feel emotionally and the way they behave are associated with how they interpret and think about a situation. *The situation itself does not directly determine how they feel or what they do.*

PEOPLE'S REACTIONS ALWAYS MAKE SENSE ONCE WE KNOW WHAT THEY'RE THINKING.

You will be particularly interested in the level of thinking that may operate simultaneously with a more obvious, surface level of thinking. As you're reading this text, you may notice these two levels. Part of your mind is focusing on the information in the text; that is, you are trying to understand and integrate factual information. At another level, however, you may be having some quick, evaluative thoughts about the situation. These cognitions are called *automatic thoughts* and are not the result of deliberation or reasoning. Rather, these thoughts seem to spring up spontaneously; they are often quite rapid and brief. You may barely be aware of these thoughts; you are far more likely to be aware of the emotion or behavior that follows.

Even if you *are* aware of your thoughts, you most likely accept them uncritically, believing they are true. You don't even *think* of questioning them. You can learn, however, to identify your automatic thoughts by attending to your shifts in affect, behavior, and/or physiology. Ask yourself, "What was just going through my mind?" when

- you begin to feel dysphoric,
- you feel inclined to behave in a dysfunctional way (or to avoid behaving in an adaptive way), and/or
- you notice changes in your body or mind that distress you (e.g., shortness of breath or racing thoughts).

Having identified your automatic thoughts, you can, and probably already do to some extent, *evaluate the validity* of your thinking. For example, when I have a lot do, I sometimes have the automatic thought "I'll never get it all finished." But I do an automatic reality check, recalling past experiences and reminding myself, "It's okay. You know you always get done what you need to."

When people find their interpretation of a situation is erroneous and correct it, they probably discover that their mood improves, they behave in a more functional way, and/or their physiological arousal decreases. In

cognitive terms, when dysfunctional thoughts are subjected to objective reflection, one's emotions, behavior, and physiological reaction generally change.

But where do automatic thoughts spring from? What makes one person interpret a situation differently from another person? Why may the same person interpret an identical event differently at one time from another? The answer has more to do with enduring cognitive phenomena: beliefs.

> THE THEMES IN PEOPLE'S AUTOMATIC THOUGHTS ALWAYS MAKE SENSE ONCE WE UNDERSTAND THEIR BELIEFS.

BELIEFS

Beginning in childhood, people develop certain ideas about themselves, other people, and their world. Their most central or *core beliefs* are enduring understandings so fundamental and deep that they often do not articulate them, even to themselves. Individuals regard these ideas as absolute truths—just the way things "are" (Beck, 1987). Well-adjusted individuals primarily hold realistically positive beliefs much of the time. But we all have latent negative beliefs that can become partially or fully activated in the presence of thematically related vulnerabilities or stressors.

Adaptive Beliefs

Many clients, like Abe, had been predominantly psychologically healthy before the onset of their disorder; they were reasonably effective, had basically good relationships, and lived in environments that were mostly safe. If so, they most likely developed flexible, helpful, reality-based beliefs about themselves, their worlds, other people, and the future (Figure 3.1). They probably saw themselves as reasonably effective, likeable, and worthwhile. They had accurate and nuanced views about other people, seeing many of them as basically benign or neutral and only some as potentially hurtful (but they most likely believed they could reasonably

protect themselves). They saw their world realistically too as composed of a mixture of predictability and unpredictability, safety and danger (but believed they could cope with most things that came their way). They perceived their future as having positive, neutral, and negative experiences (believing they could cope with misfortune—sometimes with the help of other people—and that they would be okay in the end).

EFFECTIVE CORE BELIEFS

- "I am reasonably competent, effective, in control, successful, and useful."
- "I can reasonably do most things, protect myself, and take care of myself."
- "I have strengths and weaknesses [in terms of effectiveness, productivity, achievement]."
- "I have relative freedom."
- "I mostly measure up to other people."

LOVABLE CORE BELIEFS

- "I am reasonably lovable, likeable, desirable, attractive, wanted, and cared for."
- "I am okay, and my differences don't impair my relationships."
- "I am good enough [to be loved by others]."
- "I am unlikely to be abandoned or rejected or end up alone."

WORTHY CORE BELIEFS

- "I am reasonably worthwhile, acceptable, moral, good, and benign."

FIGURE 3.1. Adaptive (positive) core beliefs about the self. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

The latent negative counterparts to these beliefs might temporarily surface when these clients negatively interpret a setback related to their effectiveness, an interpersonal problem, or an action they took that was contrary to their moral code. But they probably reverted back to their more reality-based core beliefs after a short period of time—that is, unless they developed an acute disorder. When this happens, they may need treatment to help them reestablish their primarily adaptive beliefs. The situation is different for other clients, though, especially those with personality disorders, like Maria. Their positive, adaptive beliefs may have been fairly weak or actually nonexistent when they were growing up and on into adulthood, and they usually need treatment to help them develop and strengthen adaptive beliefs.

Note that some clients hold overly positive beliefs, especially if they're manic or hypomanic. They may see themselves, others, the world, and/or the future in an unrealistically positive light. When these beliefs are dysfunctional, they may need help in viewing their experiences more realistically, which is in a negative direction.

Dysfunctional Negative Beliefs

People who have a history of being less psychologically healthy, or who live in more dangerous physical or interpersonal environments, tend to function more poorly; they may have troubled relationships, and they may hold core beliefs that are more negative. These beliefs may or may not have been realistic and/or helpful when they first developed. In the presence of an acute episode, however, these beliefs tend to be extreme, unrealistic, and highly maladaptive. Negative core beliefs about the self tend to fall into three categories (Figure 3.2):

- helplessness (being ineffective—in getting things done, self-protection, and/or measuring up to others);
- unlovability (having personal qualities resulting in an inability to get or maintain love and intimacy from others); and
- worthlessness (being an immoral sinner or dangerous to others).

HELPLESS CORE BELIEFS

- "I am ineffective in getting things done."
- "I'm incompetent, ineffective, helpless, useless, and needy; I can't cope."
- "I am ineffective in protecting myself."
- "I am powerless, weak, vulnerable, trapped, out of control, and likely to get hurt."
- "I am ineffective compared to others."
- "I am inferior, a failure, a loser, defective, useless."
- "I'm not good enough [in terms of achievement]; I don't measure up."

UNLOVABLE CORE BELIEFS

- "I am unlovable, unlikeable, undesirable, unattractive, boring, unimportant, and unwanted."
- "[I won't be accepted or loved by others because] I am different, a nerd, bad, defective, not good enough, have nothing to offer, and there's something wrong with me."
- "I am bound to be rejected, abandoned, and alone."

WORTHLESS CORE BELIEFS

- "I am immoral, morally bad, a sinner, worthless, and unacceptable."
- "I am dangerous, toxic, crazy, and evil."
- "I don't deserve to live."

FIGURE 3.2. Dysfunctional core beliefs about the self.

Clients may hold beliefs in one, two, or all three of these categories, and they may hold more than one belief in a given category.

Case Example

Reader E, who thought she was too unintelligent to master this text, frequently has a similar concern when she has to engage in a new task (e.g., renting a car, figuring out how to put together a bookcase, or applying for a bank loan). She seems to have the core belief "I'm incompetent." This belief may operate only when she is in a depressed state; it may be active some or much of the time; or it may be fairly dormant. When this core belief is active, Reader E interprets situations through the lens of this belief, even though the interpretation may, on a rational basis, be patently invalid.

Reader E tends to selectively focus on information that confirms her core belief, disregarding or discounting information to the contrary. For example, Reader E did not consider that other intelligent, competent people might not fully understand the material in their first reading. Nor did she entertain the possibility that the author had not presented the material well. She didn't recognize that her difficulty in comprehension could be due to a lack of concentration, rather than a lack of brainpower. She forgot that she often had difficulty initially when presented with a body of new information but later had a good track record of mastery. Because her incompetence belief was activated, she automatically interpreted the situation in a highly negative, self-critical manner. In this way, her belief is maintained, even though it's inaccurate and dysfunctional. It is important to note that she's not purposely trying to process information in this way; it occurs automatically.

Figure 3.3 illustrates this distorted way of processing information. The circle with a rectangular opening represents Reader E's schema. In Piagetian terms, the schema is a hypothesized mental structure that

organizes information. Within this schema is Reader E's core belief: "I'm incompetent." When Reader E is exposed to a relevant experience, this schema becomes active, and the data, contained in negative rectangles, are immediately processed as confirming her core belief—which makes the belief stronger.

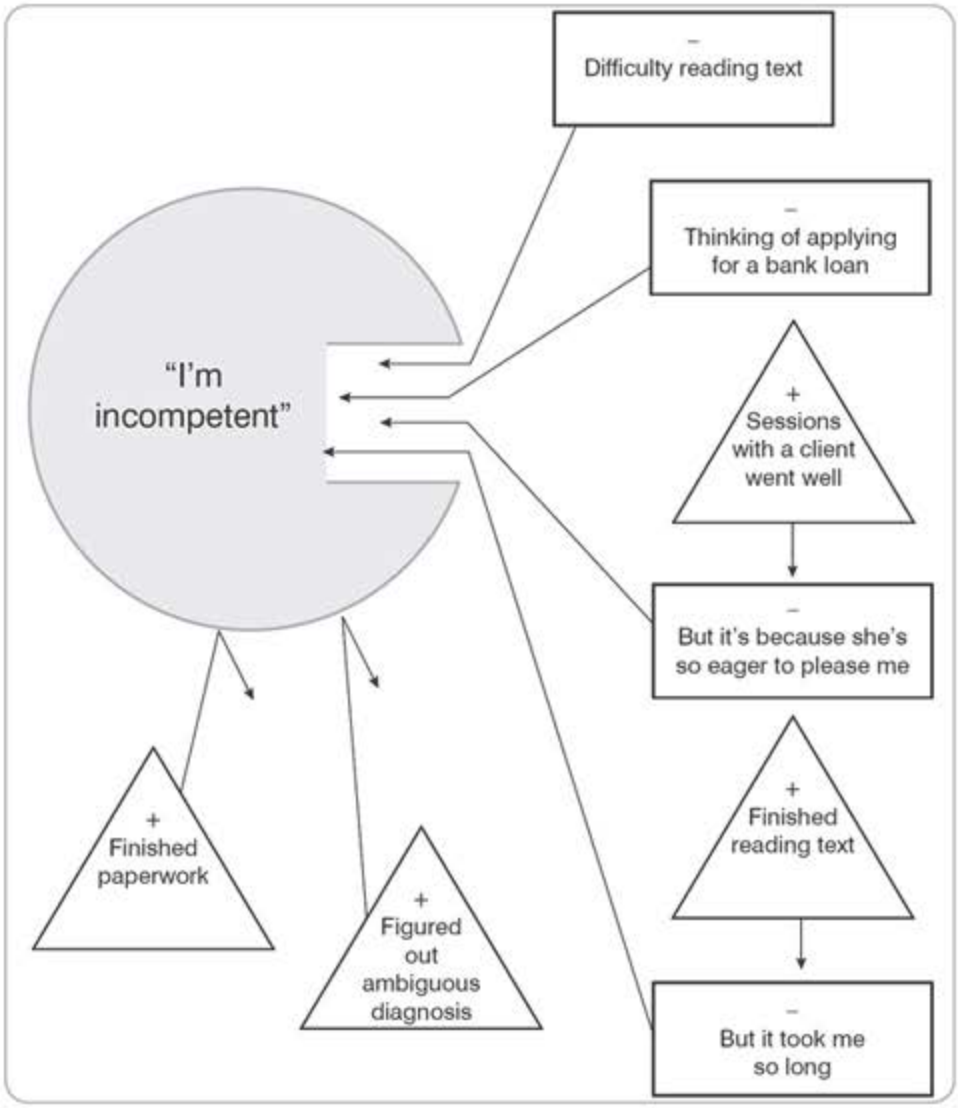


FIGURE 3.3. Information processing diagram. This diagram demonstrates how negative data are immediately processed, strengthening the core belief, while positive data are discounted (changed into negative data) or unnoticed.

But a different process occurs when Reader E encounters an experience in which she does well. Positive data are encoded in the equivalent of positive triangles, which cannot fit into the schema. Her mind automatically discounts the data. ("Yes, the session with my client went well, but that's because she was so eager to please me.") These interpretations, in essence, change the shape of the data from positive triangles to negative rectangles. Now the data fit into the schema and, as a result, strengthen the negative core belief.

There are also positive data that Reader E just doesn't notice. She doesn't negate some evidence of competence, such as paying her bills on time or helping a friend with a problem. But had she failed to take these actions, she probably would have interpreted her inaction as supporting her dysfunctional core belief. Though she doesn't discount the positive data, she doesn't seem to notice or process the positive data as being relevant to her core belief; this kind of data bounces off the schema. Over time, Reader E's core belief of incompetence becomes stronger and stronger.

Abe, too, has a core belief of incompetence. Fortunately, when Abe is not depressed, a different schema (which contains the core belief "I'm reasonably competent") is active most of the time, and his belief "I'm incompetent" is latent. But when he's depressed, the incompetence schema predominates. One important objective of treatment is to help Abe view his experiences (both positive and negative) in a more realistic and adaptive way.

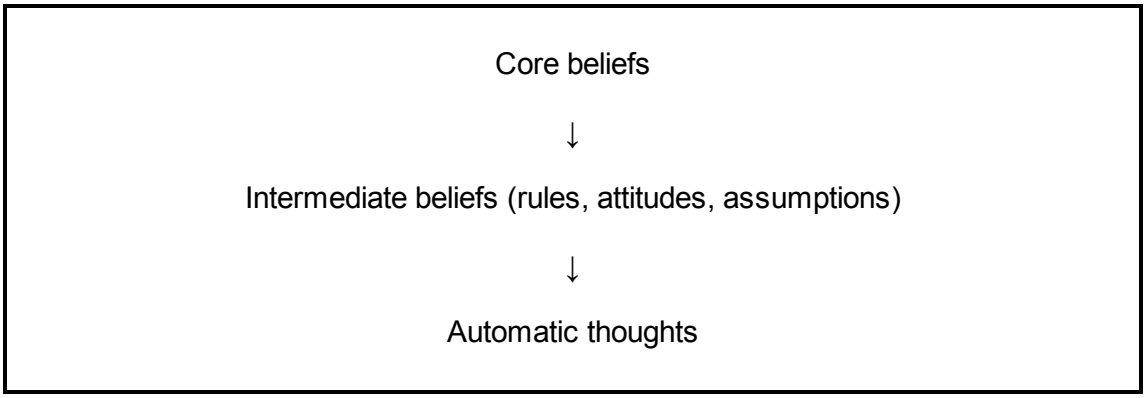
INTERMEDIATE BELIEFS: ATTITUDES, RULES, AND ASSUMPTIONS

Core beliefs are the most fundamental level of belief; when clients are depressed, these beliefs tend to be negative, extreme, global, rigid, and overgeneralized. *Automatic thoughts*, the actual words or images that go through a person's mind, are situation specific and may be considered the most superficial level of cognition. *Intermediate beliefs* exist between the two. Core beliefs influence the development of this intermediate class of beliefs, which consists of (often unarticulated) attitudes, rules, and

assumptions. Note that many attitudes indicate clients' values. Reader E, for example, had the following intermediate beliefs:

- *Attitude:* "It's terrible to fail."
- *Rule:* "I should give up if a challenge seems too great."
- *Assumptions:* "If I try to do something difficult, I'll fail. If I avoid doing it, I'll be okay."

These beliefs influence her view of a situation, which in turn influences how she thinks, feels, and behaves. The relationship of these intermediate beliefs to core beliefs and automatic thoughts is depicted below.



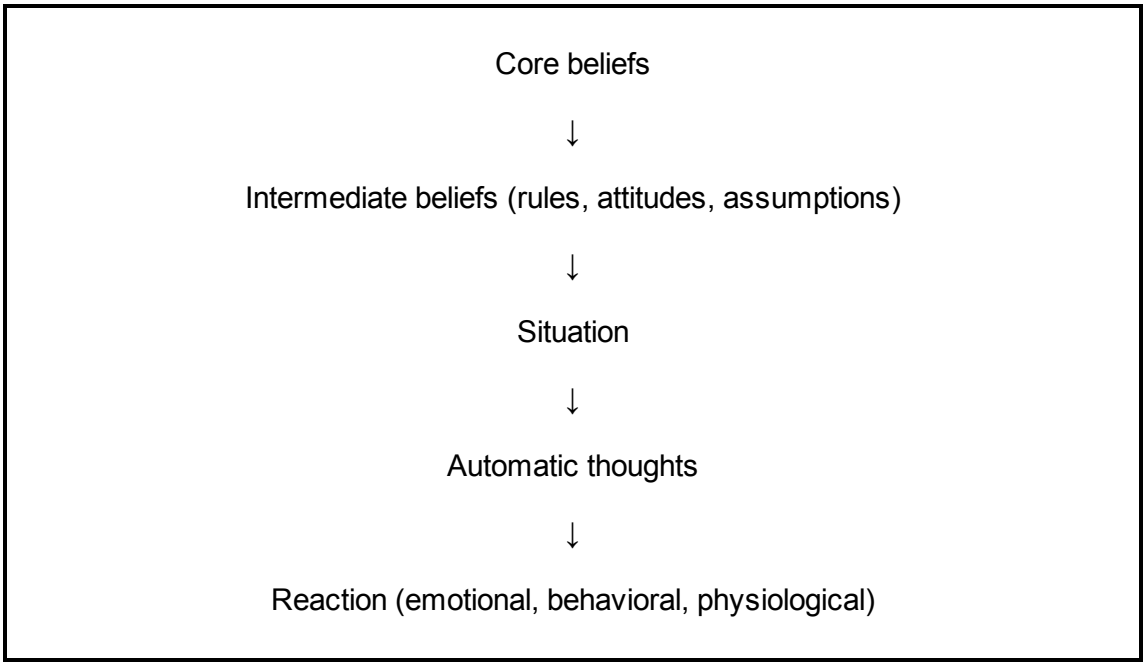
How do core beliefs and intermediate beliefs arise? People try to make sense of their environment from their early developmental stages. They need to organize their experience in a coherent way to function adaptively (Rosen, 1988). Their interactions with the world and other people, influenced by their genetic predisposition, lead to certain understandings: their beliefs, which may vary in their accuracy and functionality. Of particular significance to the CBT therapist is that dysfunctional beliefs can be unlearned, and more reality-based and functional new beliefs can be developed and strengthened through treatment.

The quickest way to help clients feel better and behave more adaptively is to help them identify and strengthen their more positive adaptive beliefs and to modify their inaccurate beliefs. Once this is accomplished, clients tend to interpret current and future situations or problems in a more constructive way. In most cases we can work both directly and indirectly on positive beliefs from the beginning of treatment. But we usually need to work indirectly on negative core beliefs at first and more directly later

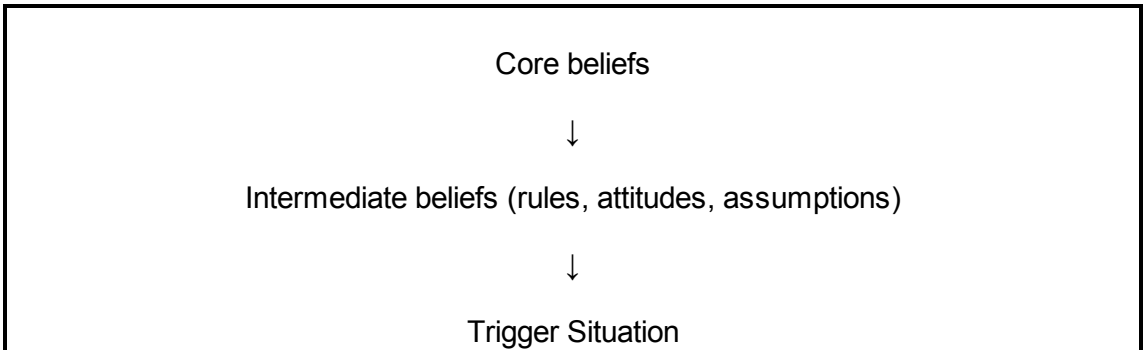
on. Even the identification of negative core beliefs can trigger significant negative affect that can lead clients to feel unsafe.

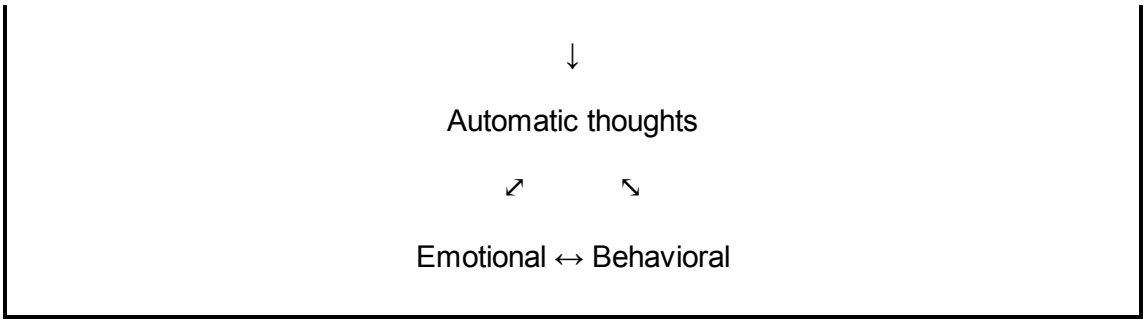
A MORE COMPLEX COGNITIVE MODEL

The hierarchy of cognition, as it has been explained to this point, can be illustrated as follows:



It's important to note that the sequence of the perception of situations leading to automatic thoughts that then influence people's reactions is an oversimplification at times. Thinking, mood, behavior, and physiology can affect one another.





There are also many different kinds of internal and external triggering situations about which clients have automatic thoughts:

- Discrete events (such as failing to get a job offer)
- A stream of thoughts (such as thinking about being unemployed)
- A memory (such as getting fired from a job)
- An image (such as the disapproving face of a boss)
- An emotion (such as noticing how intense one's dysphoria is)
- A behavior (such as staying in bed)
- A physiological or mental experience (such as noticing one's rapid heartbeat or slowed-down thinking)

Individuals may experience a complex sequence of events with many different triggering situations, automatic thoughts, and reactions. (See Chapter 12, pp. 217–218, for an example of an extended cognitive model.)

CONCEPTUALIZATION OF ABE

At intake, it's clear that Abe is suffering from persistent sadness, anxiety, and loneliness. I diagnose him with major depression, severe, with anxious distress. I ask some specific questions to help me develop an initial conceptualization. For example, I ask Abe when he generally feels the worst—which situations and/or times of day. He tells me that he pretty much feels the same all day long, but perhaps a little worse in the evenings. Then I ask him how he felt the previous evening. When Abe confirms that he was as depressed as usual, I ask, "What was going through your mind?"

Right from the beginning, I obtain a sample of important automatic thoughts. Abe reports that he often thinks, "There's so much I should be doing but I'm so tired. If I even try [to do things like cleaning up the apartment], I'll just do a bad job" and "I feel so down. Nothing will make me feel better." He also reports an image, a mental picture that had flashed through his mind. He saw himself, sometime in the indeterminate future, sitting in the dark, feeling utterly hopeless and helpless.

I also look for factors that maintain Abe's depression. Avoidance is a major problem. He avoids cleaning up his apartment, doing errands, socializing with friends, looking for a new job, and asking others for help. Therefore, he lacks experiences that could have given him a sense of mastery, pleasure, or connection. His negative thinking leads to his being inactive and passive. His inactivity and passivity reinforce his sense of being helpless and out of control.

As a child, Abe tried to make sense of himself, others, and his world, learning from, for example, his experiences, interactions with others, and direct observation. His perceptions were also undoubtedly influenced by his genetic inheritance. Early experiences within the family laid the groundwork for his core belief of competence and incompetence.

Abe was the oldest of three boys. When he was 11, his father left the family and never returned. His mother, a single parent, worked two jobs and relied heavily on him. Once his father left, she often asked Abe to do things that were quite difficult—for example, keeping the house clean, doing the laundry, and taking care of his younger brothers. Abe had a strong value of being a good son, accomplishing what was asked of him and helping others. He expected himself to be able to do everything his mother asked, but he was often not up to the task. He had thoughts such as "I should be doing this [task] better"; "I should be helping Mom more"; and "I should be able to make them [his brothers] behave." On the few occasions when he asked his mother what he should do to control his brothers' behavior better, she said irritably, "Figure it out for yourself."

Not all youth in this kind of situation perceive themselves as lacking. Some youth, for example, blame their mothers for expecting too much. Abe's mother did, in fact, expect too much of him, for his age and developmental level. She criticized him when she came home and saw his brothers "running wild" or found the kitchen messy. At these times, she became upset and told Abe, "You can't do anything right. You're letting

me down." Abe thought what she said was true, and he felt distressed. He then often retreated to his room and ruminated over his shortcomings.

Abe's Core Beliefs

Over time, Abe's belief that he was reasonably competent began to erode, in the specific context of his home life. He began to notice what he considered to be his failures. Even when he saw he was doing a good job, he tended to discount his accomplishments. "I cleaned up the kitchen, but the living room is still messy"; "I got them [brothers] to do their homework, but I couldn't make them stop fighting." No wonder Abe began to feel incompetent. The result of putting too much weight on his perceived weaknesses and discounting or failing to notice his strengths led to the development of his core belief: "I'm incompetent."

Abe's negative belief was fairly circumscribed to "failures" at home. He received average grades at school, as did his friends. His teachers and mother generally seemed satisfied with his performance, so he was satisfied too. He was an above-average athlete and received praise and support from his coaches. So Abe saw himself as reasonably competent in the context of school and sports. He also saw himself as reasonably likeable and worthwhile.

Abe's beliefs about his world and other people were, for the most part, realistically positive and adaptive. He generally believed that many people were benign—or would be benign as long as he performed well. He saw his world as relatively safe. Influenced by his father's abandonment of the family, he saw the world as potentially unpredictable, but he also thought he'd be able to cope with most circumstances. He viewed his future as unknown but potentially pretty good.

Abe was at his best when he finished high school, became employed, and moved into an apartment with a friend. During this time, his adaptive core beliefs were mostly active. He did well on the job, socialized often with good friends, exercised and kept himself in good shape, and started saving money for the future. He was honest, forthright, responsible, and a hard worker. He was pleasant to be around, often helping family and friends without being asked. He married at age 23, a year after meeting his wife. Although she tended to criticize him, he nevertheless saw himself as basically competent, worthwhile, and likeable. But he had an underlying

vulnerability of viewing himself as incompetent when he didn't live up to his self-imposed high expectations. This vulnerability developed primarily as a result of negative interactions with his mother when he was a youth.

Abe became more stressed once his children were born, and he sometimes criticized himself for not spending enough time with them. His wife was stressed too and became more critical of him. But he didn't become depressed at this point. He continued to function well as long as he perceived that he was performing at a high level at work and at home. His related belief was "If I perform highly, it means I'm okay." A problem arose when he perceived himself as functioning at a lower level, associated with his belief "If I don't perform highly, it shows I'm incompetent." It wasn't until he put a very negative meaning on his difficulties at work and on the dissolution of his marriage that his previously latent negative core beliefs became strongly activated. In addition, he saw himself as helpless and out of control (which he described as related to incompetence/failure).

Abe's Intermediate Beliefs and Values

Abe's intermediate beliefs were somewhat more amenable to modification than his core beliefs. These attitudes (such as "It's important to work hard, be productive, be responsible, be reliable, be considerate to others, honor commitments, do the right thing, and give back to others") reflected his values and his behavior, as did his rules (e.g., "I should work hard"). They developed in the same way as core beliefs, as Abe tried to make sense of his world, of others, and of himself. Mostly through interactions with his family, and to a lesser degree with others, he developed the following assumptions:

"If I work hard, I'll be okay (but if I don't, I'll be a failure)."
"If I figure things out for myself, I'll be okay (but if I ask for help, it will show I'm incompetent)."

Abe had not fully articulated these intermediate beliefs or values before therapy. But they nevertheless influenced his thinking and guided his behavior.

Abe's Behavioral Strategies

Beginning in adolescence, Abe developed certain patterns of behavior, which were mostly quite functional, to live up to his values and to avoid the activation of his core belief (and the emotional discomfort connected with it). He worked hard when he was at home, when playing sports, and when he got his first job. He set high standards for himself at work and went out of his way to help other people. On the other hand, Abe rarely asked for help, even when it was reasonable to do so. He feared others would criticize him and view him as incompetent. He felt vulnerable at times and tried to make up for what he saw as his weaknesses. While Abe's assumptions were fairly inflexible, he nevertheless got along well in life—until he perceived himself as incompetent and not living up to his values.

Sequence Leading to Abe's Depression

Throughout his life, Abe regularly had some negative thoughts about himself, particularly in situations in which he perceived his performance was subpar. "I should have done that better" was a common thought he had had growing up and later at work and at home, especially after he married and had children. The thoughts usually led to mild dysphoria, but when he resolved to put in more effort, he generally felt better.

These kinds of automatic thoughts became fairly frequent and intense preceding the onset of Abe's depressive episode, in the context of work, marriage, and home life. He had a new boss, Joseph, a man 15 years younger than he. Joseph changed Abe's work responsibilities. Abe had been in charge of customer service at a lighting company. He enjoyed working with customers and interacting with the two employees whom he supervised.

But Joseph moved him over to inventory management, which entailed little interaction with others and required him to use a software program with which he was unfamiliar. Abe started making mistakes and became highly self-critical. He had thoughts such as "What's the matter with me? This shouldn't be so hard." He interpreted his difficulties with his new responsibilities as due to his own incompetence. He became dysphoric and anxious. But he didn't become depressed—not yet.

Abe finally asked for help, but Joseph growled at him, saying that Abe should be able to figure out what to do. Instead of continuing to ask for help, Abe tried harder, but he still couldn't understand how to fulfill some of his new responsibilities. When he even considered asking for help again, he thought, "Joseph will think less of me. What if he says I'm incompetent? I could get fired." His beliefs of incompetence and vulnerability became stronger.

Soon his negative emotions started to spill over at home, as he ruminated over his perceived failures. When he developed symptoms of depression (especially a depressed mood and great fatigue), he changed his activities. He started to withdraw from others, including his wife. At dinner, he would sit almost silently, despite his wife's efforts to get him to open up. After dinner, instead of doing household tasks, he mostly sat in his armchair, ruminating over his perceived failings. On weekends, he sat on the couch for hours at a time, watching television. His wife became very impatient with him when he was reluctant to make social plans, when he helped much less around the house, and when he spoke little to her. She began to nag and criticize him much more than before. His own self-critical thoughts became more and more intense too. His avoidance led to few opportunities for him to feel competent, in control, productive, and connected to others—crucial values of his—and to a dearth of pleasurable or enjoyable activities that could have lifted his mood.

As he developed stronger symptoms of depression, he started avoiding additional tasks he thought he wouldn't do well, for example, paying bills and doing yard work. He had many automatic thoughts across situations about the likelihood that he would fail. These thoughts led him to feel sad, anxious, and hopeless. He viewed his difficulties as due to an innate flaw and not as the result of encroaching depression. He developed a generalized sense of incompetence and helplessness and curtailed his activities further. His relationship with his wife became quite strained, and they started having significant conflict. He interpreted the conflict as meaning he was failing in the marriage, that he was incompetent as a husband.

Over the course of several months, Abe's problems at work became even worse. Joseph became quite critical of Abe and downgraded him at his yearly performance review. Abe's depression intensified significantly when his wife filed for divorce. He became preoccupied with thoughts of

how he had let her and his children and his boss down. He felt like (that is, he had a belief that he was) an incompetent failure. He felt (believed he was) at the mercy of his sad and hopeless feelings ("I'm out of control") and thought there was nothing he could do to feel better ("I'm helpless"). And then he lost his job.

This sequence of events illustrates the diathesis–stress model. Abe had certain vulnerabilities: very strong and rigid values of productivity and responsibility, biased information processing, a tendency to see himself as incompetent, and genetic risk factors. When these vulnerabilities were exposed to relevant stressors (loss of job and marriage), he became depressed.

Abe's depression became maintained by the following factors or mechanisms:

- An ongoing negative interpretation of his experiences
- Attentional bias (noticing everything he wasn't doing well or not doing at all)
- Avoidance and inactivity (which resulted in few opportunities for pleasure, a sense of accomplishment, and connection)
- Social withdrawal
- Increased self-criticism
- Deterioration of problem-solving skills
- Negative memories
- Rumination over perceived failures
- Worrying about the future

These factors negatively affected Abe's self-image and helped maintain his depression. They became important targets in treatment.

Abe's Strengths, Resources, and Personal Assets

Even though Abe was severely depressed when he first came to see me, his life wasn't unremittingly negative. His children and their spouses offered him support. His mood lifted somewhat when he interacted with his grandchildren, especially around sports. He was still doing very basic self-care. Although his funds were dwindling, he had some money in savings. He was able to do a minimal amount of housework and meal preparation. Historically, he had been a highly responsible, hardworking husband,

father, and employee. He had learned many skills on the job that were potentially transferable to other jobs. He had good common sense and had been a good problem solver.

To summarize, Abe's belief that he was incompetent stemmed from childhood events, especially through interaction with his critical mother, who kept telling him that he was doing a poor job (at tasks beyond his abilities) and that he was letting her down. Nonetheless, he had neutral or relatively positive school experiences, and his dominant core belief was that he was okay. Years later, significant stress at work and at home contributed to the activation of his core belief of incompetence and to his use of maladaptive coping strategies, most notably avoidance, which triggered his belief of helplessness. He avoided asking for help, he withdrew from his wife and friends, and he sat on the couch for hours instead of being productive. In addition, he became highly self-critical. Ultimately, Abe became depressed, and his maladaptive core beliefs became fully active.

Abe's beliefs made him vulnerable to interpreting events in a negative way. He didn't question his thoughts but rather accepted them uncritically. The thoughts and beliefs by themselves did not cause the depression. (Depression is undoubtedly caused by a variety of psychosocial, genetic, and biological factors.) Abe may have had a genetic predisposition for depression; however, his perception of and behavior in the circumstances at the time undoubtedly facilitated the expression of a biological and psychological vulnerability. Once his depression set in, these negative cognitions strongly influenced his mood and helped maintain the disorder.

THE COGNITIVE CONCEPTUALIZATION DIAGRAMS

It's important to develop both strengths-based and problem-based conceptualizations. Cognitive Conceptualization Diagrams (CCDs) help you organize the considerable amount of data you get from clients. You can start filling out these diagrams (between sessions) as soon as you identify relevant information during the evaluation and first session. You'll continue to look for pertinent data throughout treatment. Most

clients, like Abe, provide you with negative data at the beginning of treatment, so it's important to ask questions to elicit positive information. It's also important to be continually on the lookout for positive data that clients overlook or discount.

The Strengths-Based Cognitive Conceptualization Diagram

The Strengths-Based Cognitive Conceptualization Diagram (SB-CCD; Figure 3.4) helps you pay attention to and organize the client's patterns of helpful cognitions and behavior. It depicts, among other things, the relationship among

- important life events and adaptive core beliefs,
- adaptive core beliefs and the meaning of the client's automatic thoughts,
- adaptive core beliefs, related intermediate beliefs, and adaptive coping strategies, and
- situations, adaptive automatic thoughts, and adaptive behaviors.

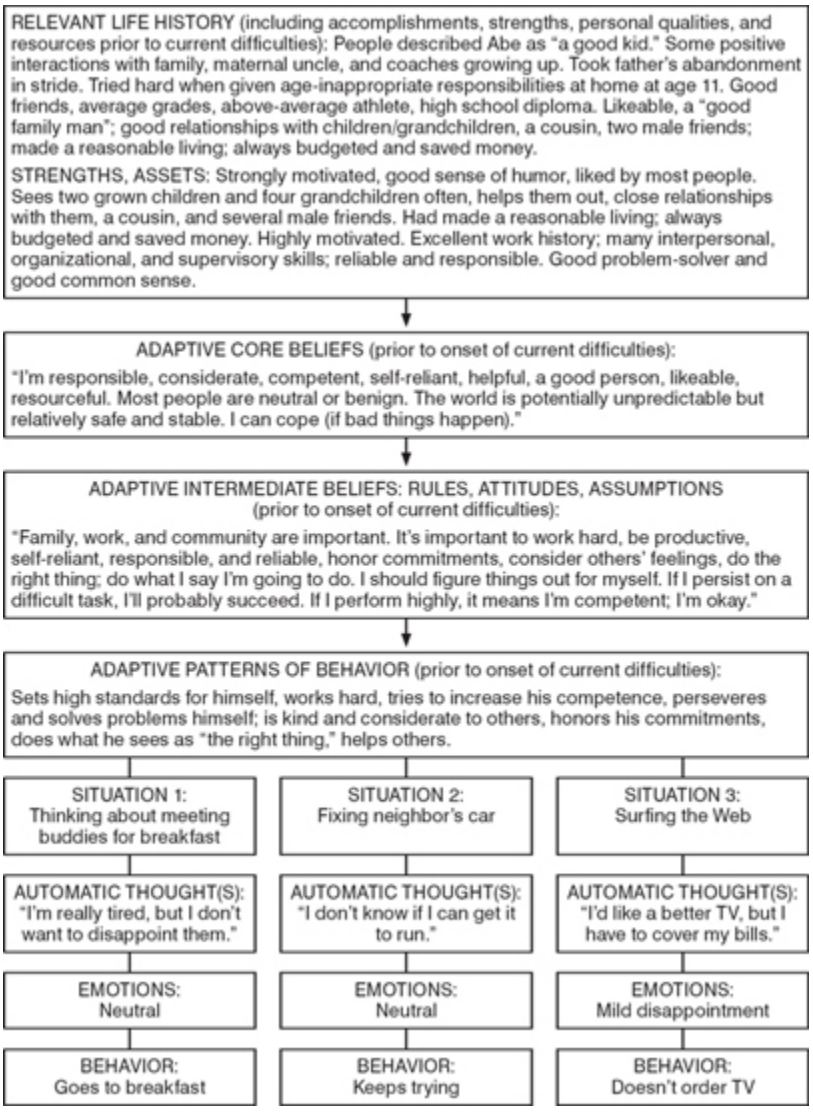

RELEVANT LIFE HISTORY (including accomplishments, strengths, personal qualities, and resources prior to current difficulties): People described Abe as "a good kid." Some positive interactions with family, maternal uncle, and coaches growing up. Took father's abandonment in stride. Tried hard when given age-inappropriate responsibilities at home at age 11. Good friends, average grades, above-average athlete, high school diploma. Likeable, a "good family man"; good relationships with children/grandchildren, a cousin, two male friends; made a reasonable living; always budgeted and saved money.
STRENGTHS, ASSETS: Strongly motivated, good sense of humor, liked by most people. Sees two grown children and four grandchildren often, helps them out, close relationships with them, a cousin, and several male friends. Had made a reasonable living; always budgeted and saved money. Highly motivated. Excellent work history; many interpersonal, organizational, and supervisory skills; reliable and responsible. Good problem-solver and good common sense.
ADAPTIVE CORE BELIEFS (prior to onset of current difficulties):
"I'm responsible, considerate, competent, self-reliant, helpful, a good person, likeable, resourceful. Most people are neutral or benign. The world is potentially unpredictable but relatively safe and stable. I can cope (if bad things happen)."
ADAPTIVE INTERMEDIATE BELIEFS: RULES, ATTITUDES, ASSUMPTIONS (prior to onset of current difficulties):
"Family, work, and community are important. It's important to work hard, be productive, self-reliant, responsible, and reliable, honor commitments, consider others' feelings, do the right thing; do what I say I'm going to do. I should figure things out for myself. If I persist on a difficult task, I'll probably succeed. If I perform highly, it means I'm competent; I'm okay."
ADAPTIVE PATTERNS OF BEHAVIOR (prior to onset of current difficulties):
Sets high standards for himself, works hard, tries to increase his competence, perseveres and solves problems himself; is kind and considerate to others, honors his commitments, does what he sees as "the right thing," helps others.
SITUATION 1: Thinking about meeting buddies for breakfast
SITUATION 2: Fixing neighbor's car
SITUATION 3: Surfing the Web
AUTOMATIC THOUGHT(S): "I'm really tired, but I don't want to disappoint them."
AUTOMATIC THOUGHT(S): "I don't know if I can get it to run."
AUTOMATIC THOUGHT(S): "I'd like a better TV, but I have to cover my bills."
EMOTIONS: Neutral
EMOTIONS: Neutral
EMOTIONS: Mild disappointment
BEHAVIOR: Goes to breakfast
BEHAVIOR: Keeps trying
BEHAVIOR: Doesn't order TV

FIGURE 3.4. Abe's SB-CCD. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

Figure 3.5 contains the questions you should ask yourself to fill it out. You'll elicit relevant data at the evaluation (e.g., when you ask clients to describe the best period in their life) for the top of the diagram and additional data for the whole diagram throughout treatment. The list in Figure 3.6 (adapted from Gottman & Gottman, 2014) can help specify their positive qualities.

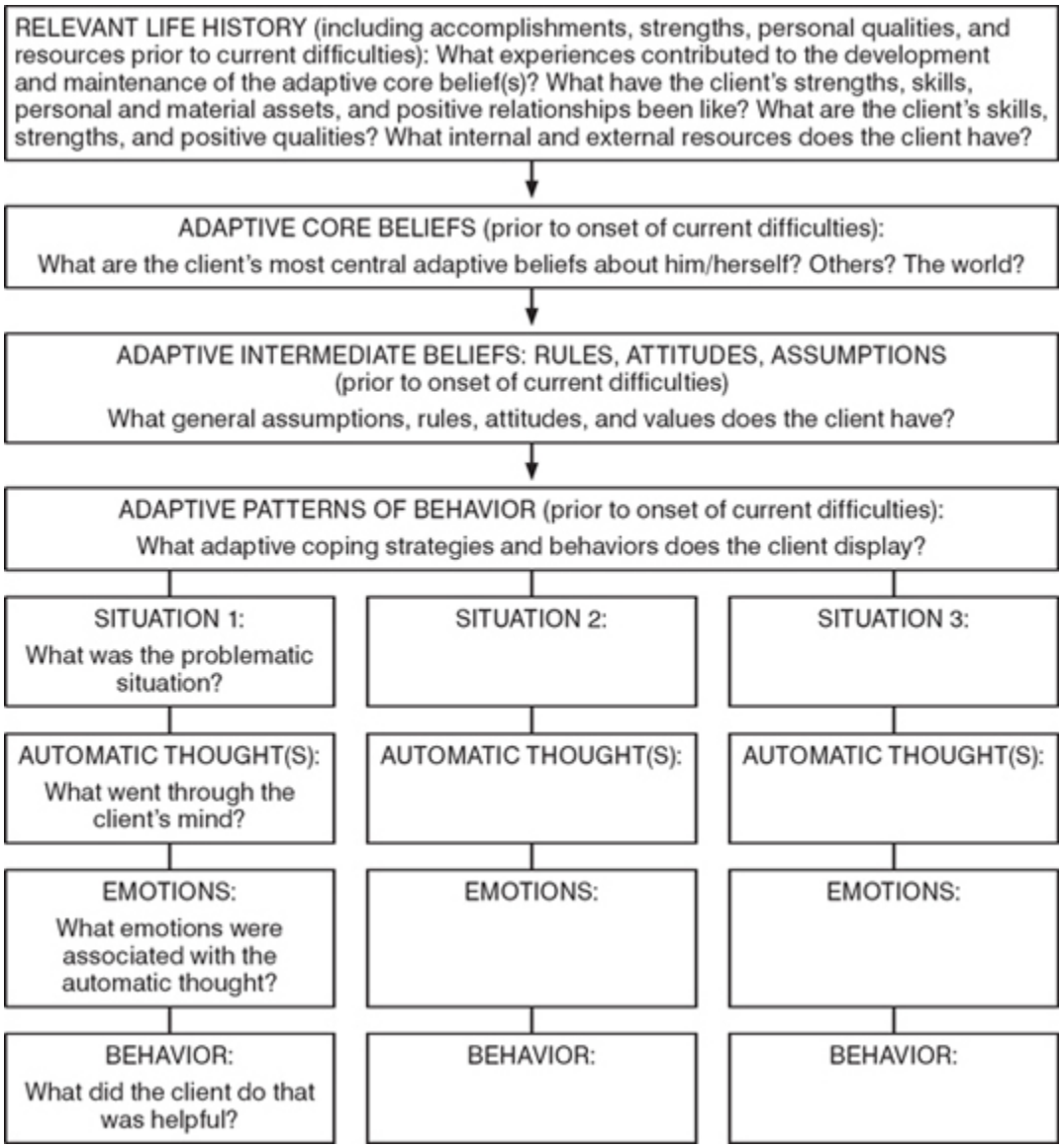

RELEVANT LIFE HISTORY (including accomplishments, strengths, personal qualities, and resources prior to current difficulties): What experiences contributed to the development and maintenance of the adaptive core belief(s)? What have the client's strengths, skills, personal and material assets, and positive relationships been like? What are the client's skills, strengths, and positive qualities? What internal and external resources does the client have?
ADAPTIVE CORE BELIEFS (prior to onset of current difficulties):
What are the client's most central adaptive beliefs about him/herself? Others? The world?
ADAPTIVE INTERMEDIATE BELIEFS: RULES, ATTITUDES, ASSUMPTIONS
(prior to onset of current difficulties)
What general assumptions, rules, attitudes, and values does the client have?
ADAPTIVE PATTERNS OF BEHAVIOR (prior to onset of current difficulties):
What adaptive coping strategies and behaviors does the client display?
SITUATION 1:
What was the problematic situation?
SITUATION 2:
SITUATION 3:
AUTOMATIC THOUGHT(S):
What went through the client's mind?
AUTOMATIC THOUGHT(S):
AUTOMATIC THOUGHT(S):
EMOTIONS:
What emotions were associated with the automatic thought?
EMOTIONS:
EMOTIONS:
BEHAVIOR:
What did the client do that was helpful?
BEHAVIOR:
BEHAVIOR:

FIGURE 3.5. The SB-CCD: Questions. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

1. Loving
2. Sensitive
3. Brave
4. Intelligent
5. Thoughtful
6. Generous
7. Loyal
8. Truthful

9. Strong
10. Energetic
11. Sexy
12. Decisive
13. Creative
14. Imaginative
15. Fun
16. Attractive
17. Interesting
18. Supportive
19. Funny
20. Considerate
21. Affectionate
22. Organized
23. Resourceful
24. Athletic
25. Cheerful
26. Coordinated
27. Graceful
28. Elegant
29. Gracious
30. Playful
31. Caring
32. A great friend
33. Exciting
34. Thrifty
35. Planful
36. Committed
37. Involved
38. Expressive
39. Active
40. Careful
41. Reserved
42. Adventurous
43. Receptive
44. Reliable
45. Responsible
46. Dependable
47. Nurturing
48. Warm
49. Virile
50. Kind
51. Gentle
52. Practical
53. Lusty
54. Witty
55. Relaxed
56. Beautiful
57. Handsome
58. Rich

59. Calm
60. Lively
61. A great partner
62. A great parent
63. Assertive
64. Protective
65. Sweet
66. Tender
67. Powerful
68. Flexible
69. Understanding
70. Totally silly
71. Shy
72. Vulnerable

FIGURE 3.6. List of positive qualities. Adapted with permission from Gottman and Gottman (2014). Copyright © 2014 J. Gottman and J. S. Gottman.

The SB-CCD is too complex to present to many clients. If you do, show them a blank copy. You can fill it out together, choosing historical (premorbid) situations in which they had adaptive automatic thoughts and behaviors. Or you can wait until the clients are currently perceiving themselves and their experiences more realistically and are engaging in helpful coping strategies.

The (Traditional) Cognitive Conceptualization Diagram

The traditional (i.e., problem-based) CCD (Figure 3.7) organizes the maladaptive information you collect about clients. You'll gather data at the evaluation and throughout treatment. Begin filling it out as soon as you begin to see patterns in the themes of clients' automatic thoughts or unhelpful behaviors. This CCD depicts, among other things, the relationship among

- important life events and core beliefs,
- core beliefs and the meaning of clients' automatic thoughts,
- core beliefs, intermediate beliefs, and dysfunctional coping strategies, and
- trigger situations, automatic thoughts, and reactions.

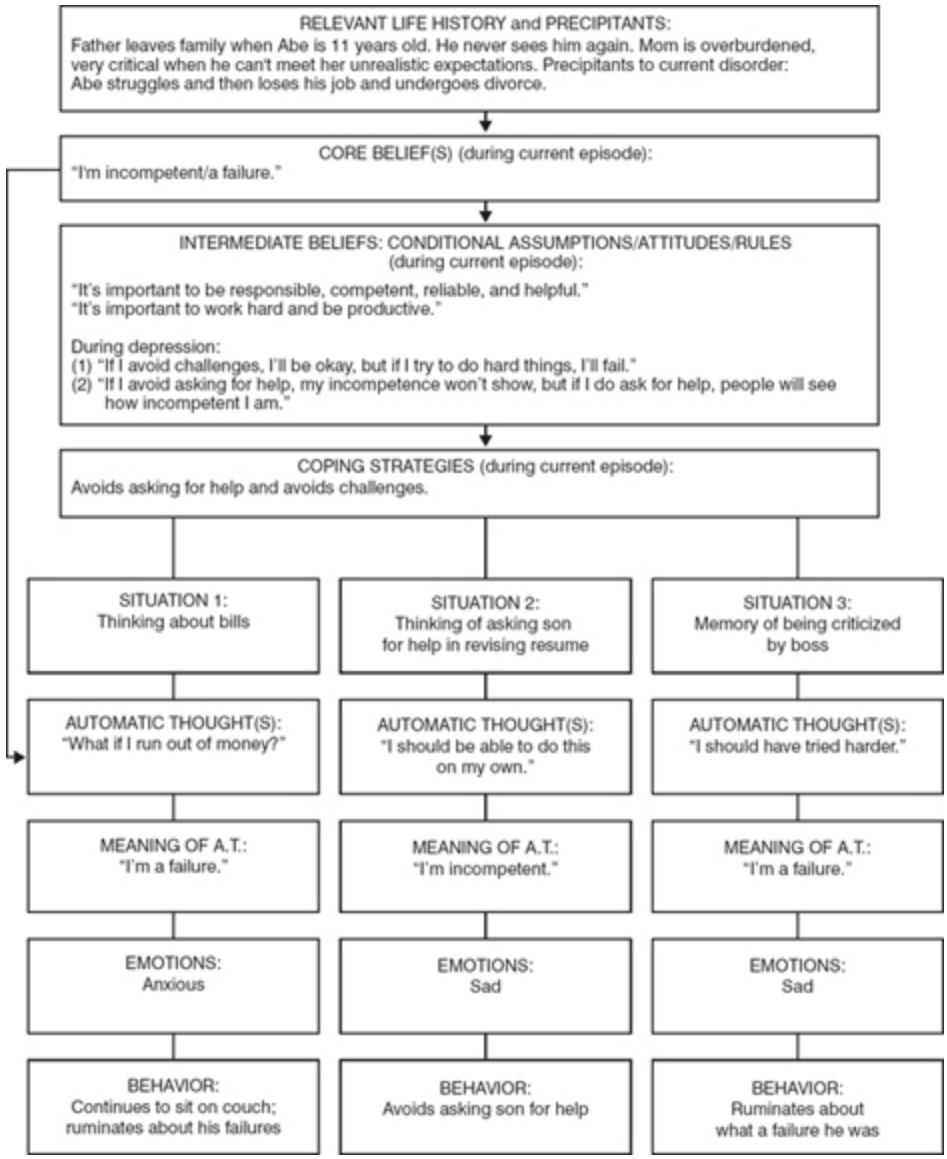

RELEVANT LIFE HISTORY and PRECIPITANTS:
Father leaves family when Abe is 11 years old. He never sees him again. Mom is overburdened, very critical when he can't meet her unrealistic expectations. Precipitants to current disorder: Abe struggles and then loses his job and undergoes divorce.
CORE BELIEF(S) (during current episode):
"I'm incompetent/a failure."
INTERMEDIATE BELIEFS: CONDITIONAL ASSUMPTIONS/ATTITUDES/RULES (during current episode):
"It's important to be responsible, competent, reliable, and helpful."
"It's important to work hard and be productive."
During depression:
(1) "If I avoid challenges, I'll be okay, but if I try to do hard things, I'll fail."
(2) "If I avoid asking for help, my incompetence won't show, but if I do ask for help, people will see how incompetent I am."
COPING STRATEGIES (during current episode):
Avoids asking for help and avoids challenges.
SITUATION 1: Thinking about bills
SITUATION 2: Thinking of asking son for help in revising resume
SITUATION 3: Memory of being criticized by boss
AUTOMATIC THOUGHT(S): "What if I run out of money?"
AUTOMATIC THOUGHT(S): "I should be able to do this on my own."
AUTOMATIC THOUGHT(S): "I should have tried harder."
MEANING OF A.T.: "I'm a failure."
MEANING OF A.T.: "I'm incompetent."
MEANING OF A.T.: "I'm a failure."
EMOTIONS: Anxious
EMOTIONS: Sad
EMOTIONS: Sad
BEHAVIOR: Continues to sit on couch; ruminates about his failures
BEHAVIOR: Avoids asking son for help
BEHAVIOR: Ruminates about what a failure he was

FIGURE 3.7. (Traditional) CCD. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

Figure 3.8 presents questions to help you fill out the CCD. When you start, regard your first efforts as tentative; you have not yet collected enough information to determine the extent to which the automatic thoughts clients have expressed are typical and important. *The completed diagram will mislead you if you choose situations in which the themes of clients' automatic thoughts are not part of an overall pattern.*

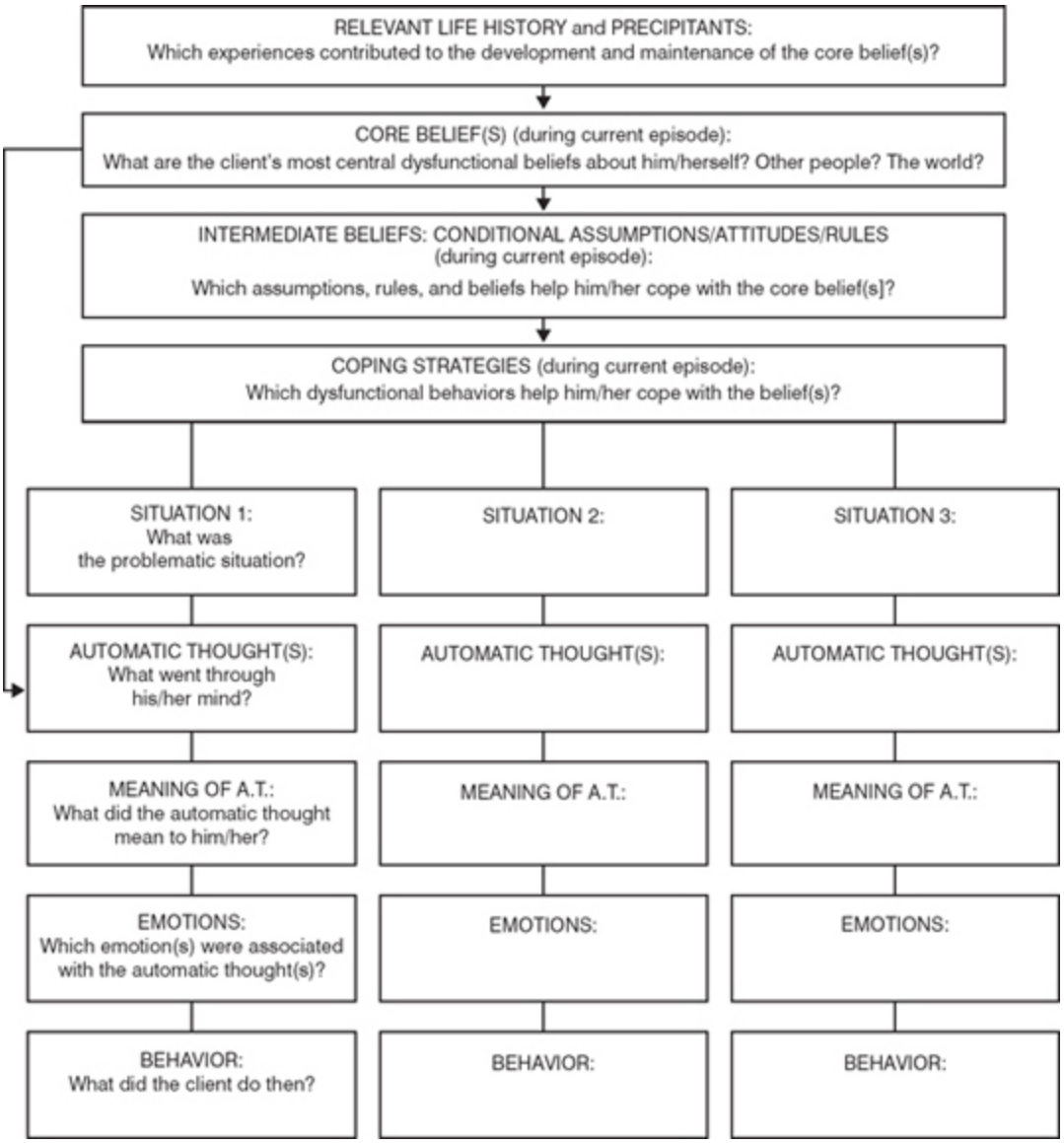


FIGURE 3.8. (Traditional) CCD: Questions. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

You share your partial conceptualization with clients verbally at every session as you summarize their experiences in the form of the cognitive model. At times, especially initially, you'll illustrate your summary via a handwritten diagram of the cognitive model. Initially, you may have data to complete only the top box (important lifetime data) and the bottom of the diagram (three cognitive models). Leave the other boxes blank or fill

in items you have inferred with a question mark to indicate their tentative status. You will check out missing or inferred items with the client at future sessions.

Fill in the bottom half of the CCD, starting with three typical current situations related to the presenting problems in which clients became upset or behaved in an unhelpful way. If clients have one more theme in their automatic thoughts, make sure to choose situations that reflect those themes. Next, fill in the key automatic thoughts and the subsequent emotion, relevant behavior (if any), and physiological reaction (sometimes important for clients with intense anxiety). If clients experience more than one emotion in a given situation, make sure to have separate boxes for each key automatic thought, followed by the emotional and behavioral reaction to that thought (Figure 3.9).

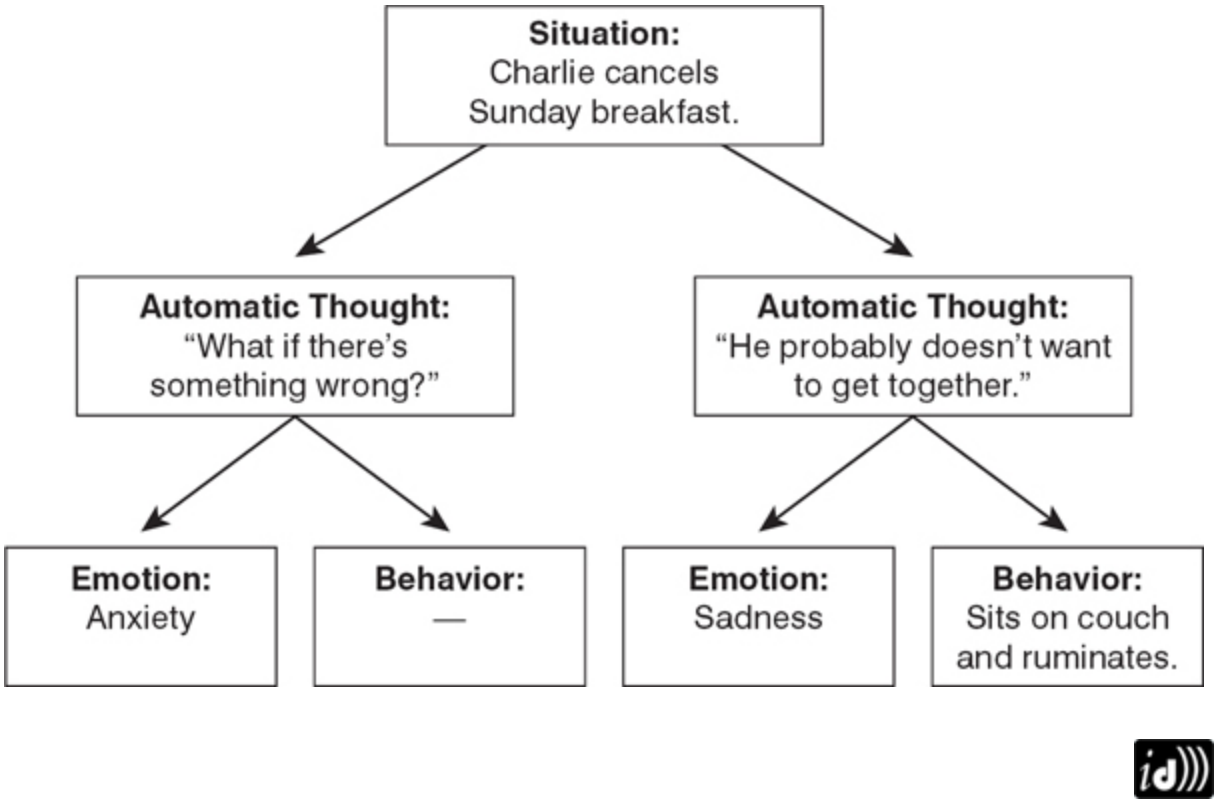


FIGURE 3.9. Adapting the CCD for additional emotions.

Early in treatment, you may avoid asking clients for the *meaning* of their negative thoughts because eliciting these deeper-level cognitions can evoke significant distress. You can hypothesize about the meanings, but include a question mark next to your hypotheses, to remind you that you

need to confirm their accuracy with clients at some point. The meaning of the automatic thought box in Figure 3.8 is below the automatic thought box because you identify the automatic thought first. In actuality, the core belief becomes activated and triggered (actually, the schema containing the core belief becomes activated) in a particular situation and gives rise to automatic thoughts (see Chapter 17).

When appropriate, usually a little later in treatment, you'll ask clients directly about the meaning of their thoughts, using the "downward arrow" technique (pp. 291–292). The meaning of the automatic thought for each situation should be logically connected with one of the client's core beliefs. Note that you don't have to ask for the meaning of an automatic thought when the cognition is pervasive and overgeneralized (not just specific to only one or a few situations). Abe's automatic thought "I'm a failure" was also a core belief because he didn't believe he was a failure in just one situation (e.g., when he saw the pile of mail on the table); when he had that thought, he meant he was an overall failure as a person.

To complete the top box of the diagram, ask yourself (and the client):

- How did the core belief originate and become maintained?
- What life events (often including those in childhood and adolescence, if any are relevant) did the client experience that might be related to developing and maintaining the beliefs?

Typical relevant childhood data include such significant events as continual or periodic strife among parents or other family members; parental divorce; negative interactions with parents, siblings, teachers, peers, or others in which the child felt blamed, criticized, or otherwise devalued; serious medical conditions or disabilities; deaths of significant others; bullying; physical or sexual abuse; emotional trauma; and other adverse life conditions, such as moving frequently, experiencing trauma, growing up in poverty, or facing chronic discrimination, to name a few.

The relevant data may, however, be more subtle: for example, youths' perceptions (which may or may not have been valid) that they did not measure up in important ways to their siblings; that they were different from or demeaned by peers; that they did not meet expectations of parents, teachers, or others; or that their parents favored a sibling over them.

Next ask yourself, "What are the client's most important intermediate beliefs: rules, attitudes, and conditional assumptions?" Unhelpful rules often start with "I should" or "I shouldn't," and unhelpful attitudes often start with "It's bad to." These rules and attitudes are often connected to client's values, or they may serve to protect the client from the activation of the core belief. Clients' broad assumptions often reflect their rules and attitudes and link their maladaptive coping strategies to the core belief. They are often phrased in this way:

> "If I [engage in the coping strategy], then [my core belief may not immediately come true; I'll be okay for the moment]. However, if I [do *not* engage in my coping strategy], then [my core belief is likely to come true]."

See Figure 3.10 for Reader E's intermediate beliefs and coping strategies, the patterns of dysfunctional behaviors that are linked to clients' intermediate beliefs. Note that most coping strategies are patterns of *normal* behaviors that everyone engages in at times. The difficulty clients experience is in the inflexible *overuse* of these strategies at the expense of more adaptive strategies in certain situations.

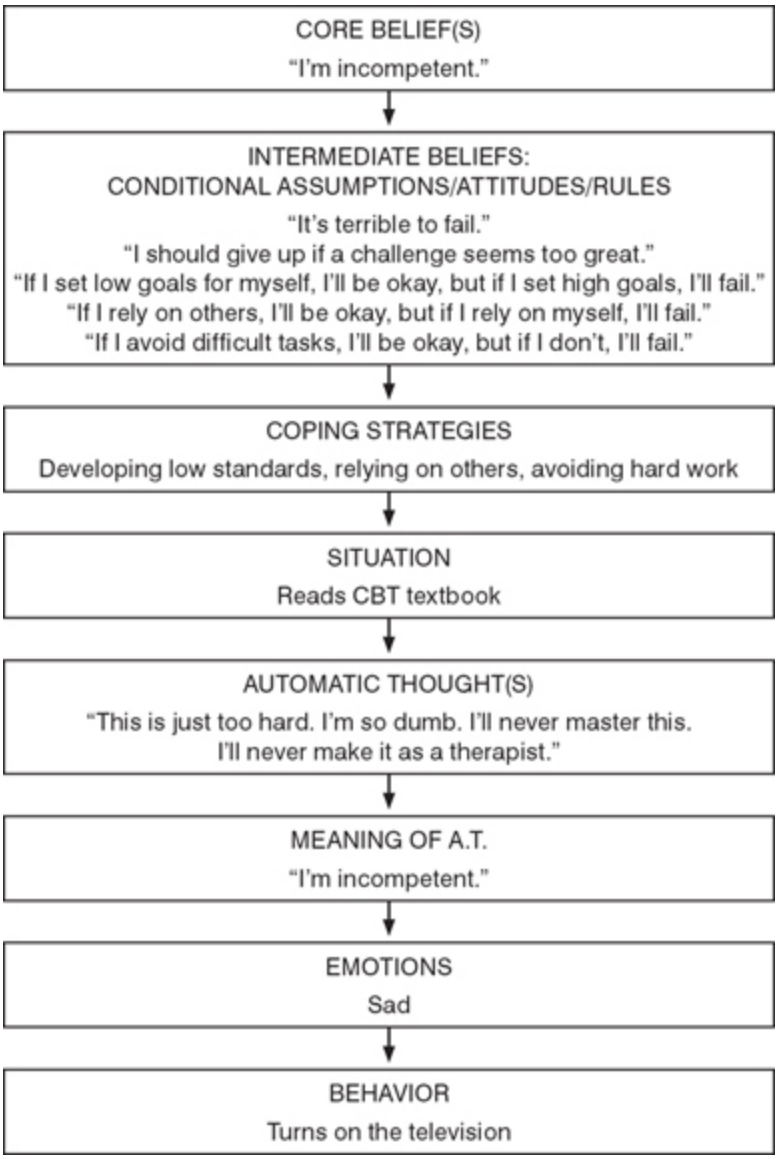

CORE BELIEF(S)
"I'm incompetent."
INTERMEDIATE BELIEFS:
CONDITIONAL ASSUMPTIONS/ATTITUDES/RULES
"It's terrible to fail."
"I should give up if a challenge seems too great."
"If I set low goals for myself, I'll be okay, but if I set high goals, I'll fail."
"If I rely on others, I'll be okay, but if I rely on myself, I'll fail."
"If I avoid difficult tasks, I'll be okay, but if I don't, I'll fail."
COPING STRATEGIES
Developing low standards, relying on others, avoiding hard work
SITUATION
Reads CBT textbook
AUTOMATIC THOUGHT(S)
"This is just too hard. I'm so dumb. I'll never master this.
I'll never make it as a therapist."
MEANING OF A.T.
"I'm incompetent."
EMOTIONS
Sad
BEHAVIOR
Turns on the television

FIGURE 3.10. Cognitive conceptualization of Reader E.

At some point, usually in the middle part of treatment, you will share the information from both the top and the bottom of the CCD, when your goal for a session is to help the client understand the broader picture. Review the conceptualization verbally, draw a simplified diagram for your client (Figure 3.11), and elicit feedback. Occasionally, clients benefit from completing a blank CCD with you. (Don't present a filled-out CCD to clients because it won't be as good a learning experience.) But many

clients would find it confusing (or demeaning if they interpret the diagram as your attempt to "fit" them into boxes). Ask clients questions to get the needed data to fill in the diagram. If you present a hypothesis, make sure to do so tentatively and ask clients whether it "rings true." Correct hypotheses generally resonate well with the client.

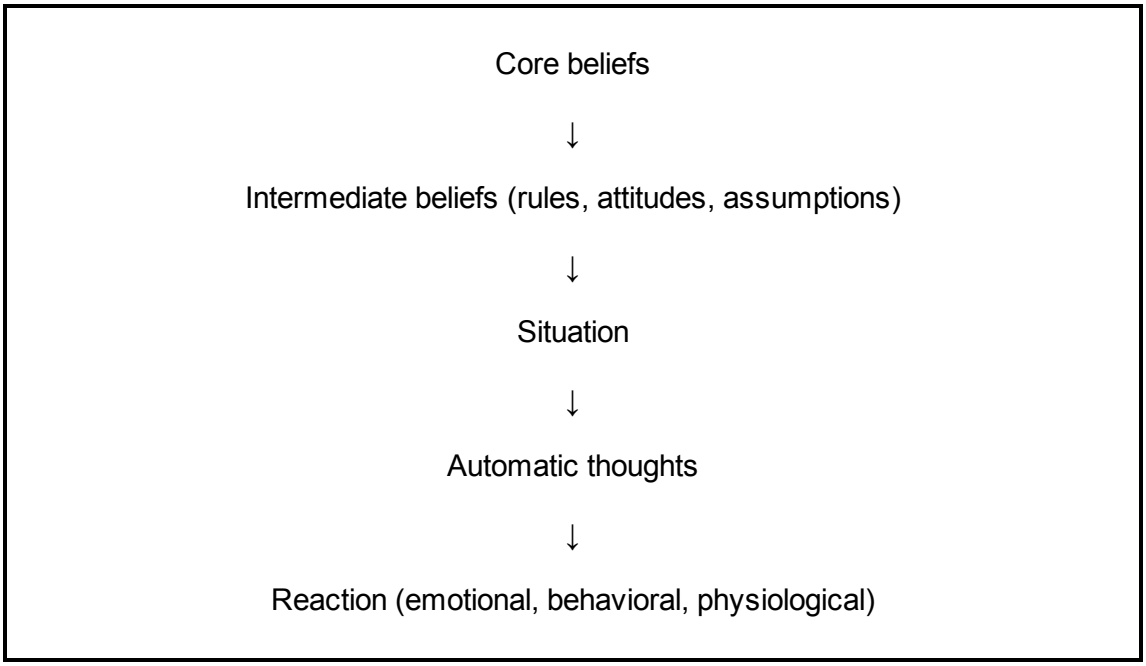


FIGURE 3.11. Simplified CCD.

To summarize, the CCDs are based on data clients present, their actual words. You should regard your hypotheses as tentative until confirmed by the client. You will continually reevaluate and refine the diagrams as you collect additional data, and your conceptualization is not complete until the client terminates treatment. While you might not show the actual diagram to clients, you will verbally (and often on paper) conceptualize their experience from the first session on, to help them make sense of their current reactions to situations. At some point, you will present the larger picture to clients so they can understand

- how their earlier experiences contributed to the development of their beliefs,
- how they developed certain assumptions or rules for living, and
- how these assumptions led to developing particular coping strategies or patterns of behavior.

Some clients are intellectually and emotionally ready to see the larger picture early on in therapy. You should wait to present it to others (especially those with whom you do not have a sound therapeutic relationship or who don't fully grasp the cognitive model or accept it as true). As mentioned previously, whenever you present your conceptualization, ask the client for confirmation, disconfirmation, or modification of each part.

Finally, an online course (*beckinstitute.org/CBTresources*) can help you master the complex process of conceptualization. And it's often helpful to practice by conceptualizing characters in a movie or a novel.

SUMMARY

Conceptualizing clients in cognitive terms is crucial to determine the most effective and efficient course of treatment. It also aids in developing empathy, an ingredient that is critical in establishing a good therapeutic relationship. Conceptualization begins at the first contact and is an ongoing process, always subject to modification as new data are uncovered and previous hypotheses are confirmed or rejected. You base your hypotheses on the information you collect, using the most parsimonious explanations and refraining from interpretations and inferences not clearly based on actual data. You continually check out the conceptualization with clients for several reasons: to ensure that it is accurate, to demonstrate your accurate understanding to them, and to help them understand themselves, their experiences, and the meanings they put to their experiences. The ongoing process of conceptualization is emphasized throughout this book, as are techniques to present your conceptualization to clients.

REFLECTION QUESTIONS

How does an individual develop depression? Why is conceptualization so important?

PRACTICE EXERCISE

Download a traditional CCD and start filling it out using Maria as the client. You'll find information about her on pages 2, 27, and 32. Keep adding to it as you get additional information. Remember to put question marks next to anything you have inferred.

4

THE THERAPEUTIC RELATIONSHIP

I think it's an act of courage for most clients to enter treatment. Many have automatic thoughts such as "What is therapy going to be like?"; "Is it really going to work?"; "Could it make me feel even worse?"; "What am I going to have to do?"; "What if my therapist pushes me too hard?"; and "What if my therapist expects too much or criticizes me?" So while I am warm, kind, and realistically optimistic throughout therapy, I am especially so at the beginning of treatment.

As far back as 1979, Aaron Beck and colleagues devoted an entire chapter to the therapeutic relationship in the first CBT treatment manual, *Cognitive Therapy of Depression*. They emphasized the Rogerian counseling skills of warmth, accuracy, empathy, and genuineness, along with basic trust and rapport. They also prescribed tailoring the relationship to the individual client, seeking agreement on the goals and tasks of treatment, sharing an interpersonal bond, and attending to clients' negative reactions to therapists and vice versa.

You will find the answers to these questions in this chapter.

- What are four essential guidelines to keep in mind at every session?
- How do you demonstrate good counseling skills?
- How do you monitor clients' affect and elicit feedback?
- How do you collaborate with clients?
- How do you tailor the therapeutic relationship to the individual?

How do you use self-disclosure?

How do you repair ruptures?

How do you help clients generalize what have they learned to other relationships?

How do you manage your negative reactions?

FOUR ESSENTIAL GUIDELINES

When I teach psychiatric residents at the University of Pennsylvania, we start our discussion on how to establish a good therapeutic relationship. Then I ask them to write themselves a virtual or actual card with four ideas, which they express in their own words. Here's a typical card:

Treat every client at every session the way I'd like to be treated if I were a client.
Be a nice human being in the room and help the client feel safe.
Remember, clients are supposed to pose challenges; that's why they need treatment.
Keep expectations for my client and myself reasonable.

I ask the residents to read their card before every therapy session. It's essential to start building trust and rapport with your clients from your first contact with them. Research demonstrates that positive alliances are correlated with positive treatment outcomes (e.g., Norcross & Lambert, 2018; Norcross & Wampold, 2011; Raue & Goldfried, 1994). Your objective is to make your clients feel safe, respected, understood, and cared for. Spend enough time on the relationship to make that happen, but ensure that you have sufficient time to help clients reach their goals, alleviate their distress, and enhance their functioning and positive mood. Research has demonstrated that the therapeutic alliance becomes strengthened when clients perceive improvement from one session to the

next (DeRubeis & Feeley, 1990; Zilcha-Mano et al., 2019). So, roll up your sleeves and get to work.

You will need to focus more heavily on the relationship when you treat clients with strong, dysfunctional personality traits or serious mental health conditions. They tend to bring the same extreme negative beliefs about themselves and others to treatment—and may assume, until strongly demonstrated otherwise, that you will view them negatively (J. S. Beck, 2005; Beck et al., 2015; Young, 1999). A good case conceptualization can help you avoid problems.

For example, Abe believed that people would look down on him because he was unemployed. He was concerned that I would too. Fortunately, I noticed a change in his facial expression during the evaluation when he first told me he was unemployed. I asked him how he was feeling. He said, "A little anxious." I asked him what was going through his mind. He told me he was afraid I was viewing him negatively. I praised him for telling me that and assured him that it made sense to me that he would have been having difficulty getting himself to look for a job, given his level of depression. He was relieved. I asked him if he'd be willing to let me know if he had any other thoughts about my being critical in the future. And I made a mental note to be on the lookout for future instances where that could happen.

DEMONSTRATING GOOD COUNSELING SKILLS

Norcross and Lambert (2018) have reviewed the research and drawn the following conclusions about the therapeutic relationship:

- Collaboration, goal consensus, empathy, positive regard and affirmation, and collecting and delivering client feedback are effective.
- Congruence/genuineness, emotional expression, cultivating positive expectations, promoting treatment credibility, managing countertransference, and repairing ruptures are probably effective.
- Self-disclosure and immediacy are promising but have not yet been sufficiently researched.

- Therapist humor, self-doubt/humility, and deliberate practice also lack sufficient research.

In CBT, the Rogerian counseling skills of empathy, genuineness, and positive regard are especially important (Elliott et al., 2011). You will continuously demonstrate your commitment to and understanding of clients through your empathic statements, choice of words, tone of voice, facial expressions, and body language. You will try to impart the following implicit (and sometimes explicit) messages, when you genuinely endorse them:

"I care about you and value you."
"I want to understand what you are experiencing and help you."
"I'm confident we can work well together and that CBT will help."
"I'm not overwhelmed by your problems, even though you might be."
"I've helped other clients with issues like yours."

If you cannot honestly endorse these messages, you may need help from a supervisor or colleague to respond to your automatic thoughts about the client, about CBT, or about yourself. And you may need additional training and supervision to increase your competence.

Important basic counseling skills, along with examples, are below.

- Empathy ("It must be so difficult for you when your ex-wife is angry").
- Acceptance of client ("It makes sense to me, given how upset you were, that you [engaged in a dysfunctional coping strategy] this week").
- Validation ("It can be really hard to start difficult conversations with people").
- Accurate understanding ("Did I get this right? She said, _____; you felt _____; you then [did _____]").
- Inspiring hope ("The reason I'm so hopeful for you is _____").
- Genuine warmth ("I'm glad you were able to get out of your apartment so many times this week!").
- Interest ("Tell me more about your grandsons").
- Positive regard ("Offering to help your neighbor was such a kind thing to do! I'm not sure everyone would be willing to put themselves out the way you did").
- Caring ("It's really important to me that I make this therapy right for you").
- Encouragement ("You know, the fact that you felt a little better when you spent some time with your friends is *such* a good sign").
- Positive reinforcement ("How great that you finally got your taxes done!").
- Offering a positive view of the client ("It sounds like it was so complicated to figure out what was wrong with your cousin's car. You're so good at things like that").

- Compassion ("I'm sorry you had such an upsetting conversation with your ex-wife").
- Humor ("You should have seen *me* when I _____").

As described later on, you'll need to figure out when and to what degree to use these basic counseling skills. But the using the right amount at the right times, can help clients

- feel likeable, when you are warm, friendly, and interested;
- feel less alone, when you describe the process of working together as a team to resolve their issues and work toward their goals;
- feel more optimistic, as you present yourself as realistically hopeful that treatment will help; and
- feel a greater sense of self-efficacy, when you help them see how much credit they deserve for solving problems, completing Action Plans, and engaging in other productive activities.

MONITORING CLIENTS' AFFECT AND ELICITING FEEDBACK

You will be continuously alert for your clients' emotional reactions throughout the session. You'll observe their facial expressions and body language, their choice of words, and tone of voice. When you recognize or infer that clients are experiencing increased distress, you will often address the issue right at the moment—for example: "You're looking a little upset. [or 'How are you feeling right now?'] What was just going through your mind?"

Clients often express negative thoughts about themselves, the process of therapy, or you. When they do, make sure to positively reinforce them. "It's good you told me that."

Then conceptualize the problem and plan a strategy to resolve it. You'll read more about how to do this later in the chapter. I hope you won't let a concern about getting negative feedback prevent you from eliciting clients' responses. If there's a problem, you need to know what it is so you can solve it! If you aren't sure what to say, try this: "It's good you told me

that. I'd like to think more about it. Is it okay if we discuss it at our next session?"

Then get advice from your supervisor or colleague and practice role-playing your response. If you don't address clients' negative feedback, they will probably be less able to focus on the work of the session. They may even decide not to return to therapy the following week.

Even when you discern that your alliance with clients is strong, elicit feedback from them at the end of sessions. For the first few sessions, you might ask, "What did you think about the session? Was there anything that bothered you, or you thought I misunderstood? Is there anything you want to do differently next time?"

After several sessions, when you believe clients will give you honest feedback, you can just ask, "What did you think of the session?"

Asking these questions can strengthen the alliance significantly. You may be the first health or mental health professional who has *ever* asked the client for feedback. I find that clients usually feel honored and respected by our genuine concern for their reactions.

You won't necessarily elicit feedback *every* time you infer the client has had a negative reaction. For example, you may be able to ignore teenage eye-rolling the first couple of times your young client engages in it. I remember an adult client of mine who often sighed. Initially, I helped her respond to her unhelpful thought, "I wish I didn't have to do that." When she sighed in subsequent sessions, I judged that we could continue with the issue we were discussing without needing to address the automatic thought associated with her sighing.

COLLABORATING WITH CLIENTS

As mentioned previously, collaboration is a hallmark of CBT. In chapter 6, you'll read more about how to start the collaborative process in the first session, and you'll see collaboration in action in many of the videos. Throughout treatment, you will foster collaboration in many ways. For example, you and your client will jointly make decisions such as

- which goals to work toward during a session;
- how much time to spend on various goals and obstacles;
- which automatic thoughts, emotions, behaviors, or physiological responses to target;
- which interventions to try;
- which self-help activities to do at home;
- how often to meet; and
- when to start tapering sessions and ending treatment.

You'll explain to clients in the first session that you and they will act as a team. You'll be transparent and ask for feedback about your goals, the process of therapy, the structure of sessions, and your conceptualization and treatment plan. Throughout this book, you'll find examples of collaborative empiricism where you and clients act as scientists, looking for evidence that supports or disconfirms their cognitions and, when relevant, seeking alternative explanations.

TAILORING THE THERAPEUTIC RELATIONSHIP TO THE INDIVIDUAL

While the counseling skills we discussed earlier are essential, so is your ability to assess and adjust the degree to which you use these skills with each client. Most clients respond positively to your use of these behaviors. But you need to be careful not to overdo it or underdo it with individual clients. For example, some clients may view warmth and empathy in a negative light and feel suspicious, patronized, or uncomfortable. Too little can lead other clients to believe that you don't value or like them. Watching for clients' emotional reactions in the session can alert you to a problem so you can change how you present yourself and help the client feel more comfortable working with you.

Your clients' cultures and other characteristics (such as age, gender, ethnicity, socioeconomic status, disability, gender, and sexual orientation) can influence the therapeutic relationship (Iwamasa & Hays, 2019). Clients may differ in the way they view you, your role, and their role.

Clients from one culture, for example, may feel more comfortable when they perceive you as an expert who takes charge in the session, while clients from another culture may perceive you as dominating the session in a disrespectful way. Some clients value your suggestions of alternative perspectives or behaviors. Other clients may be disturbed when these same suggestions are in conflict with their culturally influenced beliefs and practices.

It's important to recognize that *your* own background and culture exert an influence on *your* beliefs and values and on how you perceive, speak to, and behave toward your clients. Understanding the impact of your cultural biases helps you respond to clients in a culturally sensitive way. You may, for example, need to vary how you introduce yourself to and address clients, how you maintain eye contact, what words you choose, how you express respect, and how much self-disclosure you use, depending on the client's culture. Of course, each client is an individual for whom you develop an individualized conceptualization and an individualized treatment plan. You may find that despite significant cultural differences, any given client may respond well, without the need for you to adapt your general style.

USING SELF-DISCLOSURE

I know some therapists are taught in graduate school not to use self-disclosure. This prohibition may stem from the psychoanalytic concept of the therapist as a "blank screen." But in CBT, you don't want to be a blank screen. You want clients to accurately perceive you as a warm, authentic person who wants, and is capable, of helping them. Judicious self-disclosure can go a long way in fortifying this perception. Of course, self-disclosure should have a definite purpose, for example, strengthening the therapeutic relationship, normalizing the clients' difficulties, demonstrating how CBT techniques can help, modeling a skill, or serving as a role model.

I've found that most clients are curious about me as a person. These days, your clients may be able to find out about you through social media —so be careful what you post and what your friends and family post about

you. I'm happy to answer questions about my age, how long I've been married, how many children and grandchildren I have, where I went to school, and what my training and experience have been. If clients ask me additional questions, I gently turn the discussion back to them—for example: "We could keep on talking about me, but then we won't have as much time to talk about what's important to you, how you can have a better week. Is it okay if we turn [or get back] to _____?"

It's also acceptable and sometimes important to reveal less about yourself than I do. It is usually inappropriate, for example, to answer questions about subjects such as your dating life or alcohol use. You might say something like the following: "I'm sorry not to answer your question, but I want to focus on how I can help you."

I tend to use some self-disclosure in most sessions with most of my clients. For example, when clients are perfectionistic, I often tell them that I keep a sticky note on my desk that says, "Good enough." When they are overly responsible and say yes too often, I tell them about my sticky note that says, "Just say no." I generally do mild self-disclosures when clients are giving me an update of their week, especially when they tell me about an experience in which they felt better. For example, when Abe told me he watched a baseball game with his son and grandsons, I asked,

JUDITH: Which team are you rooting for? The Phillies?
ABE: Yes.
JUDITH: I didn't watch the game, but who won?
ABE: Unfortunately, it was the Braves.
JUDITH: Oh, too bad. How *are* the Phillies doing this season?

When Abe told me he took his granddaughters to an amusement park, I said, "My grandchildren aren't quite old enough to go there. But I did take my kids there when they were teenagers. I wonder if it's changed much over the years."

I also often use self-disclosure when a client tells me about a problem that I have experienced myself. Abe related that he was having trouble cleaning out a closet because he couldn't figure out what to throw away and what to keep.

JUDITH: I sometimes have that problem too. Should I tell you what I do?

ABE: Yes.

JUDITH: Instead of two piles, I make three. One is for things I definitely want to keep. A second is for things I definitely want to get rid of. The third is for things I'm uncertain about. I put all the uncertain things in a box for a few months. Then I go through it again. Anything I haven't used in that time probably means I can get rid of it. (*pause*) Do you think that could work for you, too?

As with any technique, pay attention to your clients' verbal and nonverbal reactions to your self-disclosures. I learned early on, for example, that many clients with narcissistic personality disorder didn't particularly appreciate hearing anything about me. Finally, be judicious in revealing your own automatic thoughts and reactions. Timing is everything! Saying something like "It makes me feel sad when I hear about what your father did when you were a child" may be inappropriate at the first session, before the client trusts your genuineness. It might be better to say, "I'm so sorry that happened to you." Expressing your genuine sadness can really strengthen your bond, though, *after* you've established a trusting relationship.

Your clients may also benefit from your reactions to their unhelpful behaviors. Here's something nonpejorative you can say when an angry client has calmed down a little. "When you get really passionate about something and yell, it makes it harder for us to figure out what to do about the problem we've been discussing." If the client takes your feedback well, you can ask him (at the time or at a later time) whether he yells loudly outside of session. If he does, you can inquire whether yelling is inconsistent with a value he holds or if it fails to produce the long-term outcome he desires.

REPAIRING RUPTURES

Why do difficulties in the relationship arise with some clients and not others? Clients bring their general beliefs about themselves, other people, and relationships to the therapy session, as well as their characteristic behavioral coping strategies. Many clients enter treatment with the beliefs

"Other people are generally trustworthy and helpful" and "Problems in a relationship can usually be resolved." If so, they tend to assume that you will accurately understand, empathize with, and accept them. They feel free to reveal their difficulties, faults, weaknesses, and fears and to express their preferences and opinions. It's relatively easily to form a collaborative team with them.

But some clients believe "Other people will hurt me" and "Problems in relationships can't be solved." These clients tend to feel vulnerable and are on guard when they start therapy, assuming you may be critical, uncaring, manipulative, or controlling. They may resist revealing what they see as their negative qualities or behaviors, either avoiding certain topics or insisting on controlling or dominating the session.

A problem obviously exists when clients give you negative feedback (e.g., "I don't think you understand what I'm saying" or "You're treating me like everyone else"). Many clients, however, allude *indirectly* to a problem, sometimes taking responsibility themselves, for example, saying, "Maybe I'm not expressing myself clearly" when they really mean, "You're not understanding me." If so, you'll need to question the client further to find out whether a problem does indeed exist and whether it's had a negative impact on the alliance.

It's important to use your conceptualization of the client to prevent or repair problems. Let's say your client has given you negative feedback (e.g., "This isn't helping") or you have inferred an affect shift and elicited an important automatic thought (e.g., "You don't care about me"). First, you provide positive reinforcement ("It's good you told me that" or the equivalent); then, you conceptualize the problem and plan a strategy.

The first question to ask yourself is "Is the client right?" If so, model good apologizing and discuss a solution. Typical mistakes include introducing a worksheet that is confusing to your client, offering a suggestion that your client finds inappropriate, proposing Action Plan items that are too difficult, misunderstanding what your client has said, or being too directive or too nondirective. Another common problem is interrupting too much (see p. 194).

At one particular session, I noticed a negative affect shift on Abe's face

JUDITH: You're looking a little distressed. What were you thinking when I asked you about the Action Plan?

ABE: I don't think I can talk to my ex-wife about our daughter. She'd just criticize me.
JUDITH: It's good you told me. I think I made a mistake to suggest it. Should we try to figure out another way to help your daughter?

After we came up with another solution, I questioned Abe further, to increase the likelihood that he'd be willing to tell me about other misunderstandings:

JUDITH: Abe, are there any other things you think I don't understand?
ABE: (*Thinks.*) No, I don't think so.
JUDITH: If I do make another mistake, do you think you could you let me know right away?

If you haven't made a mistake, the problem is likely to be related to your client's inaccurate cognitions. After positively reinforcing your client for expressing the feedback, you might do the following:

- Express empathy.
- Ask for additional information in the context of the cognitive model.
- Seek agreement to test the validity of the thought.

I did this with Maria.

JUDITH: Can we talk for a moment about phone calls?
MARIA: (*guardedly*) Okay.
JUDITH: It seems to me that at least once this week when you called me, it wasn't really a crisis.
MARIA: You don't understand! I was so upset!
JUDITH: It's good you told me that. What does it mean to you that we're even talking about phone calls?
MARIA: Well, obviously, you don't care about me or a few phone calls wouldn't bother you.
JUDITH: That's an interesting thought, that I don't care. How much do you believe it?
MARIA: 100%.
JUDITH: And how does that thought make you feel?

MARIA: Upset. Really upset.
JUDITH: It would be so important for you to find out whether that thought is 100% true, or 0% true, or somewhere in the middle. (*pause*) Other than phone calls, do you have other evidence that I don't care about you?
MARIA: (*Thinks; mutters*.) I can't think of anything.
JUDITH: Okay, is there any evidence on the other side, that maybe I do care about you?
MARIA: Not really.
JUDITH: [offering evidence] Well, do you see how I always start our sessions on time? Do I seem glad to see you? Do I seem sorry when you're upset? Do I work hard to help you?
MARIA: I guess so.
JUDITH: Could there be another explanation for why I've brought up phone calls, other than I don't care?
MARIA: I don't know.
JUDITH: Is it possible I brought it up because I know you get upset and I want to teach you some skills to reduce your distress—so you won't even have to call?
MARIA: I guess so. But when I'm upset, there's nothing I can do!
JUDITH: Which is exactly why I brought up the phone calls. I want you to build your skills so you can be confident that you can help yourself. That way, when I'm out of the picture, you'll have the choice about whether to call someone immediately—or whether to help yourself and then either call or not.
MARIA: (*Sighs*.) Okay.

HELPING CLIENTS GENERALIZE TO OTHER RELATIONSHIPS

When clients have an incorrect view of you, they may very well have a similarly incorrect view of other people. If so, you can help them draw a conclusion about your relationship and then test it in the context of other relationships.

JUDITH: Maria, can you summarize what you just learned?
MARIA: I guess you do care.
JUDITH: That's right. Of course I care. (*pause*) Maria, have you had this idea about anyone else lately?
MARIA: (*Thinks*.) Yeah. My friend, Rebecca.
JUDITH: What happened?
MARIA: Well, this was yesterday. We were supposed to go to a movie together, but she texted me at the last minute and said she wasn't feeling well and didn't want to go. But she could have invited me over! We could have watched a movie at her apartment! We've done that before.
JUDITH: And when she cancelled and didn't offer to get together in another way, what went through your mind?
MARIA: That she didn't care.
JUDITH: You know, we can use the same questions as a few minutes ago: What other evidence do you have that she doesn't care? And what's the evidence on the other side, that maybe she does care, or does care somewhat? (*pause*) But I wonder if you could just think about the next question: Is there another explanation for why she did that?
MARIA: (*Sighs*.) I don't know. Maybe she felt too sick.
JUDITH: Or she was just too tired?
MARIA: Could be.
JUDITH: Looking at it now, what do you think is most likely? Does she have a history of cancelling on you and not caring?
MARIA: (*Thinks*.) No, I guess not.
JUDITH: It's so important that you recognized that! I wonder if you have a certain vulnerability to assuming that people don't care when they actually do. (*pause*) Do you think that's possible?
MARIA: I'm not sure.
JUDITH: Well, let's keep it in mind. I'm going to put it in my notes in case it comes up again.
MARIA: Okay.

MANAGING NEGATIVE REACTIONS TOWARD CLIENTS

You and your clients have a reciprocal influence on each other (Safran & Segal, 1996). You, too, will likely bring your general beliefs about yourself, other people, and relationships to the therapy session, as well as your characteristic behavioral coping strategies. If your negative core beliefs get triggered during a session, you may react in an unhelpful way and your client may then engage in an unhelpful coping strategy.

For example, one therapist I supervised believed he was incompetent. During therapy sessions, he had lots of thoughts such as "I don't know what I'm doing," and he became quite passive and quiet. His client became uncomfortable with the silences and criticized him, which intensified his belief of incompetence. Another therapist who believed she was incompetent became angry at a client who disagreed with her, perceiving that he was implying that she didn't know what she was talking about. The client then blamed himself and became quite distressed. So, it's important to have an accurate cognitive conceptualization of both your clients' and your own beliefs and behaviors and their reciprocal interaction.

Here's something I'd like you to do at the start of every workday. Look at your schedule. Ask yourself:

> "Which clients do I wish would not come in today?"

Then use CBT techniques on yourself if any client comes to mind. Identify your cognitions about this client and do one or more of the following:

- Evaluate and respond to your cognitions about the client; create a coping card to read.
- Check on your expectations for your clients. Work on accepting them and their values as they are.
- Check on your expectations for yourself. Make sure they're realistic.
- Specify your concern and conceptualize: What might the client do or say (or not do or not say) in session (or between sessions) that could be a problem? Which beliefs might underlie this behavior?
- Cultivate nondefensiveness and curiosity.
- Problem-solve by yourself or with a colleague/supervisor.
- Set appropriate limits with clients.
- Work on accepting your own emotional discomfort.

- Do good self-care throughout the day (e.g., deep breathing, taking a walk, calling a friend, doing a short mindfulness practice, eating in a healthy way).

I remember having to do some work on myself when, for the first time, I started treating a client who had narcissistic personality disorder. I was nervous before our sessions and sometimes wished she would skip a week. My thought was "She's going to say something provocative and I won't know how to respond." I had a fair amount of evidence that she was likely to put me down in some way. In previous sessions, she had questioned my experience and expertise. She had told me she thought she was smarter than I was. She had even criticized how my office was decorated. I had to remind myself that her provocative statements were a coping strategy because she was a relatively new client who hadn't yet learned that I wouldn't put her down or make her feel inferior. In other words, she didn't feel safe enough with me.

I recognized that I could respond to some provocative statements by saying, "It's good you told me that." And/or I could ask, "If it's accurate, what would be so bad about that?" If she said, "Oh, nothing," I could make a mental note of what happened and then bring the discussion back to the issue at hand. If she continued with a provocative statement, such as "I want my therapist to be smarter than I am," I could ask, "Could we continue working together for a few more sessions until you have more information?" In any case, I was alert that my own belief of incompetency could get activated and so I prepared myself to react in a nondefensive way. Making these mental preparations allowed me to approach our sessions with curiosity ("I wonder what she'll do today to feel safe?") instead of with dread.

It's important to observe your negative reactions, accept your emotional reactions nonjudgmentally, and then figure out what to do. Once clients feel safe with you, you can address the maladaptive coping strategies they use with you—and likely with others as well. Monitor your level of empathy, and be on the alert for your own unhelpful reactions. Assess your skill deficits, engage in continual self-reflection and self-improvement (Bennett-Levy & Thwaites, 2007), get additional training, and regularly consult with others or seek supervision to increase your competence. And, when indicated, consider personal therapy.

SUMMARY

It's essential to have a good working relationship with clients. You facilitate this objective by adapting treatment to the individual, using good counseling skills, working collaboratively, eliciting and responding appropriately to feedback, repairing ruptures, and managing your own negative reactions. Clients who are in distress may have strong negative core beliefs about themselves that they bring to the therapy session. If they also have strong negative beliefs about other people, they may assume you will mistreat them in some way. That's why it's important to help clients feel safe.

REFLECTION QUESTIONS

How can you help clients feel safe in session? What automatic thoughts might interfere with your asking clients for feedback? How can you respond to those thoughts?

PRACTICE EXERCISE

Write a coping card about the therapeutic relationship that would be helpful for you to read just before your therapy sessions.

5

THE EVALUATION SESSION

Effective CBT requires you to evaluate clients thoroughly, so you can accurately formulate the case, conceptualize the individual client, and plan treatment. While there is overlap among treatments for various disorders, there are important variations as well, based on the cognitive formulation—the key cognitions, behavioral strategies, and maintaining factors—of a particular disorder. Attention to the client's presenting problems, current functioning, symptoms, and history, along with their values, positive attributes, strengths, and skills, helps you develop an initial conceptualization and formulate a general therapy plan.

You hold the evaluation session before the first treatment session. Assessment isn't limited to the initial evaluation session though. You continue to collect assessment data at each session to confirm, change, or add to your diagnosis and conceptualization and to make sure clients are making progress. It's possible to miss a diagnosis if

- you get incomplete information,
- clients deliberately withhold information (e.g., some clients with substance use problems or ego-syntonic eating disorders may do this), and/or
- you erroneously attribute certain symptoms (e.g., social isolation) to a particular disorder (depression), when another disorder is also present (social phobia).

When another clinician has performed the evaluation, you will undoubtedly need to collect additional information pertinent to the use of

CBT as the treatment modality.

In this chapter, you'll learn the answers to these questions:

What are the objectives and structure of the evaluation session?
How do you conduct the evaluation session?
What do you do in Part 1 (starting the session)?
What do you do in Part 2 (conducting the assessment)?
What do you do in Part 3 (relating your diagnostic impressions, setting broad goals, and relating your general treatment plan)?
What do you do in Part 4 (setting an Action Plan)?
What do you do in Part 5 (establishing expectations for treatment)?
What do you do in Part 6 (summarizing the session and eliciting feedback)?
What do you do between the evaluation and the first treatment session?

It will likely take between 1 and 2 hours (or possibly more) to conduct the evaluation session.

OBJECTIVES FOR THE EVALUATION SESSION

Your objectives for the evaluation session are to

- collect information (both positive and negative) to make an accurate diagnosis and create an initial cognitive conceptualization and treatment plan,
- determine whether you will be an appropriate therapist and can provide the appropriate "dose" of therapy (level of care, frequency of sessions, and duration of treatment),
- figure out whether adjunctive services or treatment (such as medication) may be indicated,
- initiate a therapeutic alliance with the client (and with family members, if relevant),
- educate the client about CBT, and
- set up an easy Action Plan.

It's desirable to collect as much information as possible before the evaluation session. Request that clients send, or arrange to have sent, relevant reports from current and previous clinicians, including both mental health and health professionals. The evaluation session itself will require less time if clients are able to fill out questionnaires and self-report forms beforehand. It's especially important that clients have had a recent medical checkup. Occasionally, clients suffer from organic problems, not psychological ones. For example, hypothyroidism can be mistaken for depression.

It's good practice to inform the client during the initial phone call that it's often useful to have a family member, partner, or trusted friend accompany the client to the evaluation session to provide additional information and/or to learn how he or she can be helpful to the client. Make sure clients understand that the evaluation will help you determine whether they are good candidates for CBT and whether you believe you will be able to provide the needed treatment.

STRUCTURE OF THE EVALUATION SESSION

In this session, you

- greet the client,
- collaboratively decide whether a family member or friend should participate in the session,
- set the agenda and convey appropriate expectations for the session,
- conduct the psychosocial assessment,
- set broad goals,
- relate your tentative diagnosis and your broad treatment plan and educate the client about CBT,
- collaboratively set an Action Plan,
- set expectations for treatment, and
- summarize the session and elicit feedback.

At this session or the first treatment session, you'll also fulfill the ethical and legal requirements where you practice. If you work in an area that doesn't have such requirements, it's still a good idea to have clients read

and sign a consent to treatment form that includes such items as risks and benefits of treatment, limits of confidentiality, mandatory reporting, and privacy of records.

PART 1: STARTING THE EVALUATION SESSION

Before clients enter your office, review whatever records they have brought and the forms they've completed. It's usually desirable to meet with clients alone at first. At the beginning of the session, you can discuss whether the client wants an accompanying family member or friend (if there is one) to attend none, part, or all of the session. It's often helpful to bring this person in at least toward the end of the session, as you convey your initial impressions (including tentative diagnosis) and review broad therapy goals. You can ask for the family member/friend's perspective on the client's problems and, if advisable, set the scene for this individual to return at some point to learn more about what he or she can do to be helpful to the client.

Setting the Agenda

Start the session by introducing yourself and setting the agenda.

JUDITH: Abe, as I explained on the phone, this is our evaluation session. It's not a therapy session, so we won't work on any issues today. We'll start doing that next time. (*pause*) Today, I need to ask you a lot of questions [providing a rationale] so I can make a diagnosis. Some of the questions will be relevant. Some won't be, but I need to ask them so I can rule in the problems you have and rule out the problems you don't have. [being collaborative] Is that okay?

ABE: Yes.

JUDITH: I'll probably need to interrupt you a few times, so I can get the information I need. If it bothers you, would you let me know?

ABE: Yes.

JUDITH: Before we begin, I'd like to tell you what to expect. This is what we call "setting the agenda," and it's something we do at every session. Today, I need to find out why you're here, and I'll ask you about the symptoms you've been having, how you've been functioning lately, and about your history. (*pause*) All right?

ABE: Yes.

JUDITH: Second, I'm going to be asking you what's going right with your life and when the best period of your life was. Then I'll ask you to tell me anything else you think I should know. Does that sound okay?

ABE: (*Nods*.)

JUDITH: Third, I'll tell you what I think your diagnosis is, but I may need to look over your records and forms and my notes and talk to you more about it next week. Fourth, I'll tell you what I think we should focus on in treatment. (*pause*) And along the way, I'll be telling you more about CBT, and I'll ask you how it all sounds. (*pause*) At the end, we'll set some broad goals for how you'd like your life to be different. Then I'll ask you whether you have any questions or concerns. Okay?

ABE: Yes.

JUDITH: Anything else you want to cover today?

ABE: Well, it would be good to know how long therapy will last.

JUDITH: (*making a note*) Good question. We'll talk about that toward the end of the session.

ABE: Okay.

PART 2: CONDUCTING THE ASSESSMENT

Areas of Assessment

You need to know about many aspects of the client's current and past experience to develop a sound treatment plan across sessions, to plan treatment within sessions, to develop a good therapeutic relationship, and to carry out effective treatment. (See Appendix B for Abe's Case Write-Up, which includes many different areas you need to ask clients about; you can download an outline with specific questions at *beckinstitute.org/CBTresources*.)

While a detailed account of assessment procedures and instruments are beyond the scope of this book, many sources can help, including Antony and Barlow (2010), Dobson and Dobson (2018), Kuyken and colleagues (2009), Lazarus and Lazarus (1991), Ledley and colleagues (2005), and Persons (2008). Note that it is critical to determine the degree to which clients might be homicidal or suicidal. Wenzel and colleagues (2009) provide assessment and practice guidelines for suicidal clients, as does an online course on suicidality (*beckinstitute.org/CBTresources*).

Eliciting a Description of a Typical Day

Another important part of the evaluation (or the first treatment session) is asking clients how they spend their time. This description gives you additional insight into their daily experience, facilitates goal setting, and helps pinpoint positive activities that you can encourage them to engage in more frequently. It also helps you identify activities clients are spending too much or too little time doing.

As clients describe a typical day, take notes and look for

- variations in their mood;
- the degree to which they are interacting with family, friends, and people at work;
- their general level of functioning at home, work, and elsewhere;
- how they're spending their free time;
- activities that bring them a sense of pleasure, accomplishment, and/or connection;

- self-care activities; and
- activities they're avoiding.

JUDITH: Abe, I'd like to get an idea of what your daily routine is like. Can you tell me what you do from the time you wake up in the morning until the time you go to sleep at night?
ABE: Okay. (*Sighs*.) Well, I usually wake up around 7 o'clock.
JUDITH: Then what do you do?
ABE: Usually I toss and turn for a couple of hours, or I just doze.
JUDITH: What time do you get out of bed for the day?
ABE: It depends. Sometimes not until 10.
JUDITH: What do you do when you first get out of bed?
ABE: I usually have coffee and a little breakfast. Some days I get dressed. Some days I don't.
JUDITH: What do you do after breakfast?
ABE: I usually just stay home. Watch TV or waste time on the computer.
JUDITH: What else do you do in the afternoon?
ABE: Sometimes I just sit on the couch doing nothing. If I have enough energy, I might run an errand, get some food. But usually I don't.
JUDITH: Do you have lunch?
ABE: I just grab some snack food.
JUDITH: Anything else you do in the afternoon?
ABE: I might do one thing, like a load of laundry. Sometimes I try to read the newspaper. But I usually just fall asleep.
JUDITH: Do you take a nap most days?
ABE: Yeah. Maybe for an hour or two.
JUDITH: What do you do for dinner?
ABE: I usually put a frozen dinner in the microwave.
JUDITH: What do you do after that?
ABE: Not much. Watch TV. Surf the web.
JUDITH: And when do you get in bed?
ABE: Around 11 or so.
JUDITH: Do you fall asleep right away?
ABE: Not usually. It sometimes takes a really long time.
JUDITH: And then do you sleep through until 7 o'clock?
ABE: Sometimes. But sometimes I'm up for a couple of hours around 3 o'clock.

Next, I ask Abe if his weekends are different from his typical weekday. Fortunately, he's a bit more active. He sometimes attends his grandson's games or visits with one of his two children and their family. He told me there had been a change in his routine about a year before. Until then, even though he was moderately depressed, he routinely had breakfast with two buddies on Saturdays and attended church on Sundays.

Collecting data in this way guides your thinking in developing an initial treatment plan. You'll also use the information in the first session when you set goals for treatment and do activity scheduling.

Responding to Hopelessness and Skepticism

Throughout the evaluation, you'll be alert for indications that the client is unsure about committing to treatment. As Abe describes his current symptoms, he expresses hopeless thinking. I use his automatic thoughts to subtly relate the cognitive model, indicate how thoughts like these would be a target of treatment, and ensure that our tentative alliance hadn't suffered.

CLINICAL TIPS

When clients offer you too much information, you can structure their responses so you'll have time to accomplish what you need to. Providing a guideline can help—for example: "For the next few questions, I just need you to answer 'yes,' 'no,' or 'I'm not sure' [or 'in one or two sentences']."

When clients start to provide unneeded details or go off on a tangent, it's important to gently interrupt: "Sorry to interrupt, but I need to know. …"

ABE: It feels like I've got so many problems. I'm not sure anything can help.

JUDITH: Okay, it's good you told me. That's an interesting thought: "I don't think anything can help." How does that thought make you feel? Sad? Hopeless?

ABE: Both.

JUDITH: This is *exactly* the kind of depressed thought that we'll be talking about starting next week. We'll need to find out whether that thought is 100% true, 0% true, or someplace in the middle. Meanwhile, is there anything I said or did that leads you to think I *can't* help, or that this kind of *treatment* can't help?

ABE: No …
JUDITH: What makes you think it might not work?
ABE: I don't know. My problems just feel overwhelming.
JUDITH: Good to know. And given your depth of depression, I'm not surprised. We'll take your problems one at a time and do problem solving together. I want you to know, you're not alone anymore. You've got me on your team.
ABE: (*Sighs in relief*.) Okay, good.
JUDITH: Now I don't have a crystal ball, so I can't give you a 100% guarantee. But there's *nothing* you've told me that makes me think it *won't* work. (*pause*) And there are a lot of things that make me think it *will* work. Should I tell you some of them?
ABE: Yeah.
JUDITH: You're obviously intelligent and very capable. You accomplished a lot and functioned highly before you got depressed. For many, many years, you did really well at work. You got promoted. You prided yourself on doing a good job. You were productive and reliable. You were a good father and you tried to be a good husband. Also, you had good friends and you helped other people. All of these are good signs.
ABE: Okay.
JUDITH: So, what do you say? Are you willing to give it a try? Do you want to come back next week?
ABE: Yeah, I do.

CLINICAL TIPS

When clients express concern because previous treatment hasn't worked, positively reinforce them ("It's good you told me that") for expressing their skepticism or misgivings. Ask whether they felt they had a good relationship with their previous therapists and whether, at *every* session, their therapists

- set agendas,
- figured out with them what they could do to have a better week,
- made sure the most important points of the session were recorded for them to review daily at home,
- taught them how to evaluate and respond to their thinking themselves,
- successfully motivated them to change their behavior, and
- asked for feedback to make sure therapy was on the right track.

Most clients have not experienced this kind of treatment, and you can say, "I'm glad to hear that your previous therapists didn't do all these things. It sounds as if our treatment here will be different. If it were exactly the same as your past experiences, I'd be less hopeful."

Don't take clients' reports at face value if they say that a previous therapist engaged in all these activities at every session. Do spend more time finding out precisely what occurred, especially whether the therapist provided treatment individualized for the client and his/her specific disorder(s), based on the latest research and practice guidelines. In any case, you can encourage the client to give your treatment a try for four or five sessions and indicate that you and the client can then review how well treatment is working.

Seeking Additional Information

Toward the end of the assessment, it's useful to ask clients two questions: "Is there anything else that's important for me to know?" and "Is there anything you're reluctant to tell me? You don't have to tell me what it is. I just need to know whether there's more to tell, maybe some time in the future."

Involving a Trusted Person

If a family member/friend has accompanied the client to the office, you might now ask the client whether he or she would like to invite the individual into the session (unless, of course, this person has been there from the beginning). Make sure there is nothing the client wants you to refrain from saying. Elicit the client's agreement for you to

- inquire what the family member/friend thinks is most important for you to know;
- ask about the client's positive qualities, strengths, and helpful coping strategies;
- review your initial diagnostic impressions; and
- present your tentative treatment plan and elicit feedback.

If the client doesn't want you to talk about all these topics or wants you to address something else, make a collaborative decision to do so, or provide a rationale for why you don't think it's a good idea.

PART 3: RELATING YOUR DIAGNOSTIC IMPRESSIONS, SETTING BROAD GOALS, AND RELATING YOUR GENERAL TREATMENT PLAN

Diagnostic Impressions

When you aren't confident of clients' diagnoses, explain that you will need time to review your notes, their forms, and previous reports. For many clients though, it's appropriate to give your initial impression of their diagnosis(es) and offer hope that you can help them.

JUDITH: Abe, you certainly are depressed. Next week, we'll talk about how I know that. Okay?
ABE: Okay.
JUDITH: The good news is that depression is treatable, and cognitive behavior therapy has been shown in dozens and dozens of studies to be effective for this condition.

Setting Goals and Relating Your General Treatment Plan

Setting goals often stimulates hope (Snyder et al., 1999), as does describing a treatment plan that makes sense to clients. It's important for them to get a concrete idea of how it is that they will recover from their condition. When you relate the treatment plan, make sure to elicit feedback.

JUDITH: Now I'd like to set some broad goals with you and tell you how I think you're going to get better and then I want to hear how it sounds to you.
ABE: Okay.
JUDITH: (*Writes "Goals" at the top of a sheet of paper and gives a copy to Abe at the end of the session.*) I know you told me you'd like to get over your depression and be less anxious, right?
ABE: Yes.

JUDITH: Would another good goal be to help you have a sense of well-being?

ABE: Yeah, that's really important.

JUDITH: Based on what you told me, we'll also work on helping you function better at home and, when you're ready, start reconnecting with people and looking for a job.

ABE: That sounds good.

JUDITH: [to avoid Abe's becoming overwhelmed] We'll do all of this step by step, so it doesn't feel overwhelming. (*pause*) How does that sound?

ABE: (*Sighs in relief.*) Good.

JUDITH: Next week, I'm going to find out what's really important to you and what you want for your life. Then we'll set more specific goals for treatment. At every session, we'll be working toward your goals. For example, next week you might say that you want to reconnect with a friend or start doing more around your apartment. We'll figure out what obstacles could get in the way and we'll do some problem solving. (*pause*) Does that sound okay?

ABE: Yes.

JUDITH: In fact, about half of what we'll do in therapy is problem solving. The other half is teaching you skills to change your thinking and how you behave. We'll especially look for depressed thoughts that could get in your way. For example, earlier in today's session you said, "I can't do anything right" and you told me how depressed you feel when you have thoughts like that. Do you see how that idea can affect your motivation to get off the couch? How it can make you feel terrible? How you might then keep watching television instead of getting busy?

ABE: Yeah, that's what happens.

JUDITH: So one thing we'll do together is evaluate thoughts like that. What's the evidence you can't do anything right? Any evidence that's not true, or not 100% true? Could there be another way of looking at this situation? For example, maybe we'll discover that because you're so depressed, you need some help in problem solving or motivating yourself. But needing help doesn't necessarily mean you do everything wrong.

ABE: Hmm.

JUDITH: Here are three things we'll do. One, we'll work together to help you change your depressed and anxious thinking to make it more

realistic. Two, we'll come up with things for you to try so you can move closer to improving your life and creating the life you want. Three, you'll learn skills you can use during the week and actually for the rest of your life. (*pause*) How does that sound?

ABE: It makes sense.

JUDITH: So that's going to be our general treatment plan: set goals, start working toward them one by one, and learn skills. In fact, that's how people get better, by making small changes in their thinking and behavior every day. [asking for feedback] Now, was there anything I just said that *didn't* sound good?

ABE: No, it makes sense.

PART 4: SETTING THE ACTION PLAN

Creating an easy Action Plan with clients at the evaluation gets them accustomed to the idea that it's important for them to carry on the work of the session throughout the week. Make sure you keep a copy of Action Plans yourself. Here's how I transitioned from relating the treatment plan to setting Abe's Action Plan.

JUDITH: Good. I'll write down some of what we just talked about so you can look at it during the week [Figure 5.1]. What should we call the things you're going to do between sessions? Your Action Plan? Self-help activities? Something else?

ACTION PLAN *May 6*

Put this Action Plan next to the coffee maker and read it every morning and again later in the day.

1. *Therapy Notes: When I start to feel more depressed, remind myself that the therapy plan makes sense. With Judy's help, I'll be working toward goals every week, step by step. I'll learn how to evaluate my thinking, which may be 100% true, or 0% true, or somewhere in the middle. The way I'll get better is by making small changes in my thinking and behavior every day.*
2. *Take grandchildren out for ice cream.*
3. *Give myself credit for doing all of the above and for doing anything that's even a little difficult—because I do it anyway.*

FIGURE 5.1. Abe's evaluation Action Plan.

ABE: Action Plan is good.
JUDITH: Do you think you could read this Action Plan twice a day, once in the morning and once later on, especially if you start to feel more depressed?
ABE: Yeah, I can do that.
JUDITH: How will you remember to read it?
ABE: I'll put it next to the coffee maker. I have coffee every morning, so I'll see it.
JUDITH: And every time you read it, I'd like you to give yourself credit.
ABE: Okay.

JUDITH: You know, when people are depressed, it's like they're trying to walk through quicksand. Everything is harder. Have you found that?
ABE: Yeah.
JUDITH: So actually, I'd like you to give yourself credit whenever you do anything on your Action Plan and anything that's even a little bit hard but you do it anyway. You can just say something like "It's good I did that." (*pause*) Could you try giving yourself credit this week?
ABE: Yeah.
JUDITH: Okay, I'll write that down, and we'll talk more about credit next week. Now what do you want to remind yourself if you start to feel hopeless?

Abe and I then jointly composed the following:

> "When I start to feel more depressed, remind myself that the therapy plan makes sense. With [my therapist's] help, I'll be working toward goals every week, step by step. I'll learn how to evaluate my thinking, which may be 100% true, or 0% true, or somewhere in the middle. The way I'll get better is by making small changes in my thinking and behavior every day."

JUDITH: So, you'll do most of the work of therapy between sessions. (*pause*) I wonder if there's something meaningful you could do this week to demonstrate to yourself that you can make a change. (*pause*) Could you do something you haven't done for a while, maybe with a family member?
ABE: (*Thinks*.) I could take my grandchildren out for ice cream.
JUDITH: Excellent. And when you do, could you tell yourself that this is an important first step in taking control of your depression? And give yourself credit?
ABE: Yes.
JUDITH: Should I write that down?
ABE: Yeah.

PART 5: ESTABLISHING EXPECTATIONS FOR TREATMENT

It's important to give clients reasonable expectations for treatment (Goldstein, 1962). Doing so can help reduce the possibility of termination (Swift et al., 2012) and lead to better treatment outcomes (Constantino et al., 2012). You should give clients a general sense of how long they should expect treatment to take. Usually it is best to suggest a range, 2 to 4 months for many clients with straightforward major depression, although some might need fewer sessions (or be constrained by finances or insurance). Other clients, particularly those with chronic psychiatric disorders, or those who are comorbid with substance use or personality disorders, may require more treatment. Clients with severe or recurrent mental illness may need more intensive treatment when they are more highly symptomatic, and periodic booster sessions for a very long time.

Many clients make progress with weekly sessions. But if their symptoms are severe or their functioning is at quite a low level, they may need to see you more frequently, especially initially. Toward the end of treatment, you will gradually space sessions farther apart to give clients more opportunities to function independently.

Here's how I give Abe an idea of how I expected therapy would proceed.

JUDITH: If it's okay with you, Abe, we'll plan to meet once a week until you're feeling significantly better, then we'll move to once every 2 weeks, then maybe once every 3 or 4 weeks. We'll decide how to space out therapy together. Even when we decide to end, I'll recommend that you come back for a "booster" session once every few months for a while. (*pause*) Okay?

ABE: Yeah.

JUDITH: It's hard to predict now how long you should be in therapy. My best guess, given how severe your depression is, is somewhere around 15 to 20 sessions. If we find that you have some long-standing issues that you want to work on, it could take longer. Again, we'll decide *together* what seems to be best. Okay?

PART 6: SUMMARIZING AND ELICITING FEEDBACK

At the end of the evaluation, you'll summarize the session to give the client a clear picture of what was accomplished. First, remind the client that treatment will start next week. Then elicit the client's reaction to the session. Here's what I say to Abe:

JUDITH: Okay, I'd like to summarize what we covered today, if that's all right. I told you that this is an evaluation session, not a therapy session, and that we'd really start to work on reaching your goals and solving your problems next week. Right?

ABE: Yeah.

JUDITH: I asked you lots of questions, and I gave you a tentative diagnosis. You told me how you spend your time on a typical day. I told you a little about how your thoughts can make you feel depressed and that when people are depressed, their thoughts may be true or they may be not true. Right?

ABE: Yes.

JUDITH: I also told you a little about this kind of therapy and what I thought your treatment plan should focus on, and we created an Action Plan for you for the coming week. Then we discussed the mechanics of treatment, for example, how often we'll meet and how long treatment will last. (*pause*) Any final questions? Or was there anything you thought I got wrong or didn't understand?

ABE: No, I think you understand me pretty well.

JUDITH: Good. Then I'll see you next week for our first therapy session.

ACTIVITIES BETWEEN THE EVALUATION AND FIRST TREATMENT SESSION

Before the first therapy session, you'll write up your evaluation report and initial treatment plan. If you haven't already done so, you'll obtain consent and contact the client's previous mental health and health

professionals to request reports, ask questions, and obtain additional information. You'll also contact relevant current professionals to discuss your findings and coordinate care. Talking by phone to other professionals often reveals important information that had not been documented in writing. You'll also start to devise a tentative cognitive conceptualization and an initial treatment plan. (See also Chapters 3 and 9.)

SUMMARY

In your initial session with a client, you will conduct a thorough assessment to collect data so you can accurately conceptualize and diagnose your client and plan treatment. You seek to accomplish many objectives, including developing the therapeutic relationship, increasing the client's hope, educating the client about CBT and the cognitive model, addressing hopelessness and skepticism, setting broad treatment goals, relating your general treatment plan, setting an Action Plan, establishing expectations for treatment, and summarizing and eliciting feedback. Following this session, you confirm the diagnosis and, when relevant, contact former and current health and mental health care providers who have treated or are treating the client. You will continue to assess the client at every session, to ensure your diagnosis is correct, to refine your conceptualization of the client, and to monitor progress.

REFLECTION QUESTION

What's important to accomplish during the evaluation session in addition to collecting data to make a diagnosis?

PRACTICE EXERCISE

Create a partial Case Write-Up about a real or imaginary client (Parts One and Two in Appendix B).

6

THE FIRST THERAPY SESSION

The most important objective in the first session is to inspire hope. You do this by providing psychoeducation (e.g., research shows that CBT is effective for the client's condition), reiterating the general treatment plan, directly expressing your confidence that you can help the client feel better, and identifying the client's values, aspirations, and goals.

You'll also establish rapport and trust with clients, socialize them into treatment, do a mood check (so you can monitor progress and adjust treatment), collect additional data for the conceptualization, teach clients about the cognitive model, schedule activities or work on an issue, develop a new Action Plan, and elicit feedback. See Figure 6.1 for the structure of the first therapy session. You'll learn how to structure future sessions in Chapter 9.

In addition to the elements listed below, you may interweave psychoeducation, eliciting and responding to automatic thoughts, devising Action Plan items, and identifying goals throughout the session.

Initial Part of Session 1

1. Do a mood (and, when relevant, a medication or other treatment) check.
2. Set the agenda.
3. Ask for an update (since the evaluation) and review the Action Plan.
4. Discuss the client's diagnosis and provide psychoeducation.

Middle Part of Session 1

5. Identify aspirations, values, and goals.
6. Do activity scheduling or work on an issue.
7. Collaboratively set a new Action Plan; check on likelihood of completion.

End of Session 1

8. Provide a summary.
9. Check how likely it is that the client will complete the new Action Plan.
10. Elicit feedback.

FIGURE 6.1. Structure of the first therapy session.

You'll find the answers to the questions below in this chapter.

How do you do a mood/medication (or other treatments) check?
How do you set an initial agenda?
How do you ask for an update and review the Action Plan?
How do you provide psychoeducation about depression, negative thinking, the treatment plan, and the cognitive model?
How do you elicit values, aspirations, and goals?
How do you set an Action Plan?
How do you summarize the session and elicit feedback?

Before the first session, review the client's intake evaluation and keep your initial conceptualization and treatment plan in mind as you conduct the session. Because it's important to tailor treatment to the individual, be prepared to change course if necessary. Most standard CBT outpatient sessions last for about 45 to 50 minutes, but the first one usually takes an hour. Try to identify one or more of the client's automatic thoughts sometime during the session. Then you can introduce or reintroduce the cognitive model. Or you can provide clients with an example. Also, look for opportunities during the session to generate positive emotions, for example, by having clients create a visual image in their minds of having achieved their aspirations, by having a brief conversation about their interests and values, and/or by using self-disclosure.

CLINICAL TIPS

- You may want to write key words of the structure on your Session Notes (Figure 10.1, pp. 176–177) prior to the session, so you can remember what to do.
- You'll provide a significant amount of psychoeducation in the first session. A booklet such as *Coping with Depression* (J. S. Beck, 2020) reviews important concepts and can be suggested as an Action Plan item.

MOOD CHECK

At the beginning of the session, greet the client and do a mood check. Research shows that when therapists and clients routinely track progress and therapists use feedback to improve their treatment, outcomes are enhanced (Miller et al., 2015). You can use published scales, such as the Beck Depression Inventory–II (Beck et al., 1996), the Beck Anxiety Inventory (Beck & Steer, 1993a), and the Beck Hopelessness Scale (Beck & Steer, 1993b). Or you can use scales in the public domain, such as the Patient Health Questionnaire (PHQ-9; *www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf*) or the Generalized Anxiety Disorder Scale (GAD-7; *www.integration.samhsa.gov/clinical-practice/gad708.19.08cartwright.pdf*). If clients are unable or unwilling to fill out forms, you can assess their mood by asking them to assign a number on a scale (0–10) that represents how they've been feeling. You might say, "If 10 means the most depressed you've ever felt and 0 means not depressed at all, how strong was the depression for most of the past week?" It's also good to ask clients to rate their sense of well-being on a 0–10 scale as illustrated in the dialogue below.

It's especially critical to check on the level of clients' suicidality (and/or aggressive and homicidal impulses). Elevated scores on items of suicidality and hopelessness indicate the client may be at risk. If so, do a risk assessment (Wenzel et al., 2009) to determine whether you will need to spend the next part of the session (or the entire session) developing a plan to keep the client safe. It may also be important to check more specifically about other problems, such as sleep, anxiety symptoms, and impulsive behaviors. These issues may be important for the agenda. An advantage of having clients fill out symptom checklists is that you can quickly identify problems without having to ask additional questions.

If you use symptom checklists, also elicit a subjective description ("How have you been feeling this week?") from clients and match it with their objective test scores. Regardless of how you measure their mood, make sure that clients are not reporting how they feel just that day but, instead, are providing an overview of their mood for the past week. Alert

clients that you'd like to continue checking their mood every week. You might say:

> "I'd like you to come to every session a few minutes early so you can fill out these forms. [providing a rationale] They help give me a quick idea of how you've been feeling in the past week, although I'll always want you to describe how you've been doing in your own words too."

As you'll see below, I start the session by checking on Abe's mood. As he's speaking, I quickly review the PHQ-9 and GAD-7 scales he filled out just prior to the session. And I ask him to rate his sense of well-being. (I want to make sure we're not only decreasing his depression and anxiety but also helping him feel better more generally.)

JUDITH: Hi, Abe. How are you doing today?
ABE: Eh, not so good.
JUDITH: Not so great?
ABE: No.
JUDITH: Is it all right if I take a look at the forms you filled out?
ABE: Sure.
JUDITH: Thanks for filling them out. [repeating the rationale] I think I mentioned last week that they help both of us make sure you're making progress over time. (*looks at forms*) Let's see. How do you think your mood is compared to what it was last week?
ABE: Probably about the same.
JUDITH: That's what the forms look like too. This one, which measures depression (*shows him the PHQ-9*), was 18 last week and this week (*pause*), and this one, which measures anxiety (*shows him the GAD-7*), is still 8. (*pause*) Could you also tell me how much of a sense of well-being you've had for most of the week? Zero means no sense of well-being, and 10 means the greatest sense of well-being you've ever experienced.
ABE: About a 1, I guess.

CLINICAL TIPS

The mood check should be brief. When clients give you too many details, you might apologize for interrupting and then say one of two things:

"Could you summarize how you've been feeling this week in just a sentence or two?" or "Could we put how you've been feeling [or the issue you've just been describing] on the agenda and get to it in a few minutes?"

MEDICATION/OTHER TREATMENTS CHECK

When clients take medication for their psychological difficulties, you'll briefly check on adherence, problems, and side effects. It's important to phrase the adherence question in terms of frequency—not "Did you take your medicine this week" but rather "How many times this week were you able to take your medicine the way [the provider] prescribed?" (See J. S. Beck, 2001, and Sudak, 2011, for suggestions on how to increase medication adherence.)

Whether your client is taking medication or receiving a different kind of treatment (e.g., electroconvulsive therapy, transcranial magnetic stimulation, or other brain stimulation therapies), you should obtain clients' permission and then periodically contact the provider to exchange information. You won't recommend changes in medication, but you might help clients respond to obstacles that are interfering with their being fully adherent. When clients have concerns about issues such as side effects, dosage, addiction to medications, or alternative medications or supplements, help them record specific questions to ask their provider and suggest that they write down the provider's answers. If clients aren't taking medication, but you believe a pharmacological or other intervention is indicated, you might propose that they have a medical or psychiatric consultation.

CLINICAL TIPS

If clients are hesitant to set up a consultation, they may be willing to look at the advantages and disadvantages of scheduling a consultation versus the advantages and disadvantages of not scheduling a consultation. It's helpful to suggest to them that they don't have to commit to taking medication or receiving an adjunct treatment; they can just get more information and then decide.

INITIAL AGENDA SETTING

Ideally, you set the agenda quickly. Most clients feel comfortable when you tell them how you'd like to structure the session. When you explain the rationale, you make the process of therapy more understandable to clients—which helps to elicit their active participation in a structured, productive way.

JUDITH: [being collaborative] If it's all right with you, what I'd like to do now is to set the agenda. [providing a rationale] The reason we set an agenda is so I can find out what's most important to you and so we can figure out together how to spend our time. Since it's our first session, we have a lot to cover, and we'll have less time to talk about your agenda items. We'll have much more time, starting next week. (*pause*) Is that okay?"

ABE: Yes.

JUDITH: You'll also notice that I take a lot of notes [providing a rationale] so I can remember what's important. Let me know if that bothers you.

ABE: Okay.

Next, you'll name your agenda items.

JUDITH: The first thing I want to do is to get an update of what happened between last session and this session [providing a rationale] so I can see if there are other important things for us to cover today. I'd like to see what you were able to get done on your Action Plan and then talk a little bit about your diagnosis.

ABE: Okay.

JUDITH: Next, we'll set some goals, and if we have time, we'll talk about some things you can do this week as part of your new Action Plan. Or we'll start working on one of your goals. (*pause*) And then at the end of the session, I'm going to ask you for some feedback. (*pause*) Does that sound all right?

ABE: Yes.

JUDITH: [eliciting Abe's agenda items] Anything else you want to make sure and talk about?

ABE: No, that sounds like a lot. That'll be enough.

Be alert for potentially important issues that arise during the session. You and the client may decide together that a new issue is more important than the ones on the original agenda. But be careful not to let clients drift into talking about a different issue without calling their attention to it. If this happens, make a collaborative decision about whether to continue talking about the new issue or to return to the original one.

UPDATE AND REVIEW OF THE ACTION PLAN

In traditional CBT, we would ask for an update in this way: "What happened between last session and this session that I should know?" This invariably led to a recounting of negative experiences, especially early in treatment. We'd then ask, "What happened that was positive?" As you'll see below, in CT-R (Beck et al., in press), we tend to start with positive experiences and help clients draw adaptive conclusions. The update is frequently intermingled with a review of the Action Plan.

JUDITH: You know, Abe, when people are depressed, they're usually preoccupied with all their problems. [providing a rationale] So it's important to focus on what's actually going okay. I wonder if you can think over the past week and tell me when you were at your best?
ABE: (*Thinks*.) That would have been when I took my grandson Ethan out for ice cream.
JUDITH: So you *were* able to do that?
ABE: Yes.
JUDITH: [giving positive reinforcement] That's great. That was part of your Action Plan.
ABE: Yeah. It was good.
JUDITH: [becoming conversational to try to lighten his mood] Did *you* get ice cream?
ABE: Yeah.
JUDITH: And how about Ethan? Did he have a good time?
ABE: I think so.

Next, I get Abe to focus on this experience and draw positive conclusions about it and about himself.

JUDITH: So, what was good about taking him?
ABE: Well, just getting out and doing something was good. We were outside for a while, but probably just being with him and hanging out was the best part.
JUDITH: [asking more questions to help Abe to reexperience the positive event] What did you talk to him about?
ABE: Mostly about soccer because he's on a team. So, we talked about how he's doing and how things are coming along for him.
JUDITH: [being conversational, showing interest] How *is* he doing? Is he a good player?
ABE: Well, according to him, he's doing pretty well. I haven't seen him lately, so I don't know. I think so.
JUDITH: [trying to elicit a positive core belief] Abe, what does it say about you that you were able to take him out for ice cream? You told me last week that it's something you hadn't done in a long time.
ABE: Seemed like something I should have done a long time ago.

Reinforcing the Cognitive Model

Like many clients, Abe expressed a self-critical automatic thought. I take the opportunity to frame it according to the cognitive model.

JUDITH: I see. And I bet you wish you *had* done it a long time ago. [discovering whether Abe has put a negative meaning on his avoidance] Why do you think you haven't done it for so long?
ABE: I don't know. I keep thinking, "Everything is too hard."
JUDITH: When you have the thought "Everything is too hard," how does that thought make you feel emotionally? [providing a multiple choice] Happy, sad, anxious?
ABE: Sad. Really sad.
JUDITH: And what do you usually end up doing?
ABE: Just sitting on the couch.
JUDITH: So, did I get this right? It sounds as if this kind of thing has been happening a lot. [summarizing in the form of the cognitive model] The

situation is that you're deciding whether or not to do something, like taking your grandson out, and you have the thought "Everything is too hard." This thought makes you feel bad and you end up usually sitting on the couch.

ABE: That sounds right.

I could then have helped Abe respond to his automatic thought. Instead, to stay on track, I continue on with the update.

JUDITH: Well, maybe we'll come back to this thought in a little while. To get back to the update, did anything else happen between last session and this session that I should know?

ABE: Nothing I can think of. I didn't do much.

Action Plan Review

If you and the client agreed on an Action Plan during the evaluation, it's important to find out what the client did and to what degree it was helpful. I start by reviewing the therapy notes we had composed the week before.

JUDITH: Can we look at your Action Plan and see what else you were able to get done? Do you have it with you?

ABE: Yeah.

JUDITH: Oh, good. Were you able to put it next to your coffee maker and read it every morning and again later in the day?

ABE: I read it every morning, but I didn't read it much later on.

JUDITH: Okay. (*Makes a mental note to discuss reading the new Action Plan twice later in the session.*) Could you read the therapy notes right now and tell me what you think about them?

ABE: "When I start to feel more depressed, remind myself that the therapy plan makes sense."

JUDITH: Okay, does it still make sense to you?

ABE: Yes, it still makes sense.

JUDITH: What else does the note say?

ABE: "With Judy's help, I'll be working toward goals every week step by step. I'll learn how to evaluate my thinking, which may be 100% true or 0% true or somewhere in the middle."

JUDITH: What do you think about that? Because you're depressed, your thinking might not always be completely true.
ABE: Well, mostly up until now, my thinking *seems* 100% true.
JUDITH: (*making a note*) Let's get back to that in a little while. What's next?
ABE: (*reading*) "And the way I'll get better is by making small changes in my thinking and behavior every day."
JUDITH: Exactly.

Next, we review the activities on the past week's Action Plan.

JUDITH: Let's see what's next. You *were* able to take Ethan out for ice cream. And how about the third item? Do you want to read that?
ABE: "Give myself credit for doing all of the above, for doing anything else that helps me get over the depression, and for doing anything that's even a little difficult, but I do it anyway."
JUDITH: So, were you able to give yourself credit for taking Ethan to ice cream?
ABE: Not very well, no. I should just do that stuff [automatic thought].
JUDITH: Well, in a few minutes, we're going to talk about your depression and how that's been getting in the way. Were you able to give yourself credit for reading your therapy notes every morning?
ABE: I did, most of the time anyway.
JUDITH: That's good.

Next, I summarize, to make the process of therapy more understandable and to keep us on track.

> "Okay, we checked your mood, we set the agenda, you gave me an update, and we reviewed the Action Plan. Next, I'd like to talk about your diagnosis."

DIAGNOSIS AND PSYCHOEDUCATION ABOUT DEPRESSION

Most clients want to know their general diagnosis and to establish that you don't think they're crazy or strange or abnormal. It's usually better to avoid the label of a personality disorder (and sometimes a serious mental health condition) at the first session and instead describe the difficulties the client has experienced, for example: "It looks as if you have major depressive disorder. It also seems that you've had some long-standing problems with relationships and with work. Is that right?"

It's desirable to let clients know *how* you made the diagnosis and to give them some initial psychoeducation about their condition. We want them to start attributing some of their problems to their disorder instead of to their character. Thoughts such as "There's something wrong with me"; "I'm lazy"; or "I'm just no good" will negatively affect their mood—and probably their behavior—and thus reduce their motivation.

JUDITH: I'd like to talk about your diagnosis. Abe, you have a real illness. It's called depression. Now a lot of people go around saying "I'm depressed" from time to time. But that's very different. When people say, "I'm depressed," usually that's like having a common cold—but [offering an analogy] what *you* have is like a really bad case of pneumonia. You see how pneumonia and the common cold are very different?

ABE: Yes.

JUDITH: You have a real illness that's called depression. I know that because I have a book that helps me diagnose the problems people have when they come to see me. It's abbreviated as the DSM. It lists the symptoms of the real illness called depression. (*pause*) And I found from talking to you last week that you really *do* have this.

Next, I list the symptoms he's been having that indicate he has the illness of depression.

"Tell me if I'm right. You're tired all of the time. You've felt very, very depressed for a long time. You've lost interest in almost everything. You rarely get a sense of pleasure. Your appetite has been off. You've been sleeping much, much more. You have trouble concentrating and making decisions, and sometimes you even think

about death. (*pause*) These are all symptoms of what's called a major depressive disorder. It's a real illness."

Having described his symptoms, I want to offer Abe hope.

JUDITH: Fortunately, research shows that there's a really good treatment for it: cognitive behavior therapy. That's the kind of treatment that I do. (*pause*) So, what do you think of this idea—that you *do* have a real illness?

ABE: I mean, what you said makes sense, and I do all that stuff. It describes me. I don't know about the idea of illness. A lot of this seems like I'm just not doing what I'm supposed to be doing.

Analogizing Depression and Pneumonia

JUDITH: If you had a terrible case of pneumonia, would you be able to do everything that you should be doing?

ABE: No.

JUDITH: No, because you'd be very tired all of the time, right?

ABE: (*Nods.*)

JUDITH: You might even have trouble concentrating if your symptoms were really severe. Your depression is every bit as real as pneumonia. And part of this real illness, Abe, is your depressed thinking.

Psychoeducation about Depression and Negative Thinking

Clients may start to blame themselves for their symptoms. Here's what I say to Abe to head that off.

JUDITH: Now, it's not your *fault* that you have depressed thinking. These thoughts just pop up automatically. In fact, we call them "automatic thoughts." (*pause*) And depressed automatic thoughts are a symptom of depression, just like tiredness and sleeping too much and having a depressed mood are symptoms. (*pause*) Okay?

ABE: Yes.

JUDITH: Abe, when people are depressed, [offering a metaphor] it's as if they're wearing the blackest glasses imaginable. And they see all of their experience as coming through these black glasses. So, everything looks very dark and very negative. (*pause*) What do you think about that?

ABE: I guess that could be right.

Additional Psychoeducation about the Treatment Plan and Depressed Thinking

Next, to inspire hope, I preview how we're going to deal with his depressed thoughts.

JUDITH: Because you're depressed, we know for sure that some of your automatic thoughts just aren't 100% true. Others may be true, but they're really unhelpful. I'm going to teach you how to evaluate your thoughts, so you can see for yourself how accurate or helpful they are. Okay?

ABE: Okay.

JUDITH: I also want to give you another analogy. When people are depressed … well, it's like horses in races that wear blinders. Why do they have them?

ABE: So they don't get distracted. To keep them looking only straight ahead.

JUDITH: Exactly. And when people are depressed, it's as if they have blinders too. All they can see is what's immediately ahead of them. And all of those things, because they have black glasses on, seem really terrible and really negative. One of the things that we'll do, Abe, is to open up those blinders so you can see *everything* that's going on, not just the negative.

ABE: Okay.

JUDITH: Do you think it would be helpful to remember that this week?

ABE: Yeah, probably.

Next, we collaboratively create a therapy note for Abe to read daily between sessions.

JUDITH: Do you want to write this down, or do you want me to write it down?
ABE: You can.
JUDITH: Okay. Maybe we should start this out, "When I criticize myself, remember …" And what do you think would be good to remember?

Asking Abe to summarize in his own words allows me to check on his level of understanding, makes him more active in the session, and reinforces the adaptive response in his mind.

ABE: I'm only looking at part of the scene.
JUDITH: Yes, "I'm only looking at part," and what part are you looking at?
ABE: The part through my black glasses.
JUDITH: Yes. "I'm only looking at part of the scene, and it's through black glasses."

To make the response more robust, I offer two other ideas.

JUDITH: And how about "It's not my fault I'm doing this"?
ABE: (*Sighs.*)
JUDITH: Doesn't sound like you really believe that?
ABE: Not too much.

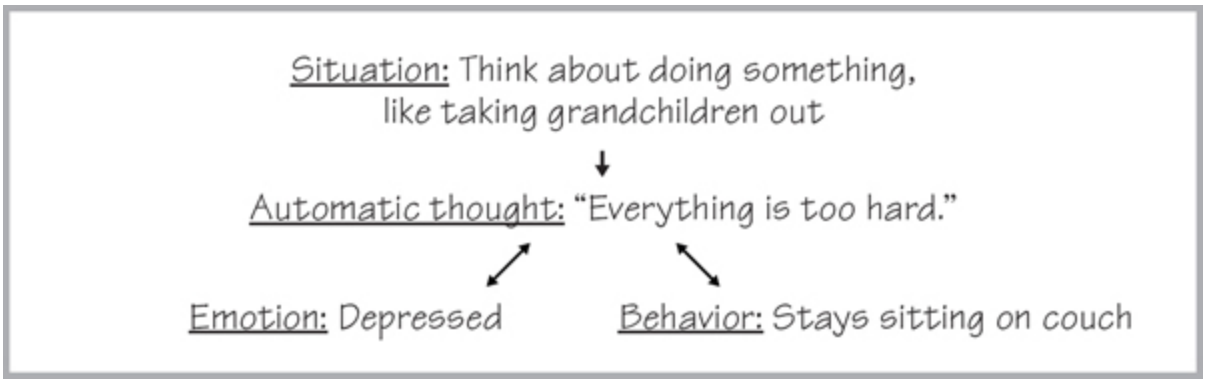
I don't want to write down anything Abe disagrees with, so I modify the idea.

JUDITH: How about "*Judy* says it's not my fault"?
ABE: Okay.
JUDITH: Is that all right?
ABE: Yeah.
JUDITH: "Judy says it's not my fault." And why do I say you're doing this?
ABE: Because I have depression.
JUDITH: Right. "It's happening because I have depression." (*pause*) Do you think that this is something that you could read to yourself this week?
ABE: Yeah, yeah. I can do that.

Psychoeducation about the Cognitive Model

In the next part of the session, I explain, illustrate, and record the cognitive model with Abe's own examples. I also ask Abe to put what I had said in his own words so I could check on his understanding.

JUDITH: The next thing I'd like to do is to talk just a little bit more about your depressed thinking. Here's the situation that just happened a few minutes ago. We were talking about why you hadn't taken Ethan for ice cream for a long time. That was the situation, and do you remember what you were thinking? What your thought was?
ABE: I'm not sure.
JUDITH: You said, "Everything is too hard."
ABE: Oh.
JUDITH: Right? And so, when you had that thought, "Everything is too hard," how did it make you feel?
ABE: Really depressed.
JUDITH: And what did you usually end up doing?
ABE: Just sitting on the couch.
JUDITH: Let me draw a diagram that shows this.


Situation: Think about doing something, like taking grandchildren out
Automatic thought: "Everything is too hard."
Emotion: Depressed
Behavior: Stays sitting on couch

Now if you'd had another thought, I wonder if you would have felt differently. For example, if you had thought "Well, everything *seems* too hard, but because I'm depressed that might not be true. Therapy makes sense. Judy says that she can help me, and I already did something good by taking Ethan out for ice cream." If you had had those thoughts, how do you think you would have felt?
ABE: Better.

JUDITH: Exactly. (*Pointing to the cognitive model diagram.*) It's not the situation directly that makes you feel tired or bad or depressed. It's what you're *thinking* in that situation. So, if you have the thought "Everything is too hard," of course you're going to feel depressed and sit on the couch. If you have a thought like "Well, therapy makes sense. Judy says she can help me," then you might feel a little bit better and you might be a little more likely to do something.

ABE: I can see that.

JUDITH: One of the things that's going to be really important in this treatment is to have you learn to identify your automatic thoughts. This is just a skill, like learning to ride a bike. I'm going to teach you how to do it. And then we're going to figure out whether a thought is 100% true or 0% true or someplace in the middle. (*pause*) So, I wonder, before you took Ethan out for ice cream, were you thinking that it would be a very hard thing to do?

ABE: Yeah.

JUDITH: And then how did it turn out?

ABE: Pretty good.

JUDITH: Was it as hard as you expected?

ABE: No.

JUDITH: So, that's a really good example of how you could have an automatic thought like "This is too hard" or "It's going to be very hard to take him out," but it might turn out not to be true, or not 100% true. Is that right?

ABE: Yes.

JUDITH: So, I wonder, could you tell me in your own words then what we've just been talking about here?

ABE: Well, I guess you're saying that I have all these negative thoughts because I'm depressed.

JUDITH: Right. And what effect do these thoughts have on you?

ABE: They make me feel bad and then I might just sit on the couch.

JUDITH: Oh, well, that's excellent. You're right. Your thinking affects how you feel and then what you do. In fact, if you had thought "It's too hard to take Ethan out" instead of just "It's very hard," what do you think would have happened?

ABE: I don't know. I might not even have called him.

See Chapter 12 (pp. 222–225) to find out what to do when clients have difficulty identifying automatic thoughts. But be careful to downplay the importance of identifying automatic thoughts when they struggle. You don't want clients to think they're incompetent.

CLINICAL TIPS

If you have difficulty identifying one of your client's automatic thoughts, you can provide an example:

THERAPIST: I'd like to talk for a couple of minutes about how your thinking affects how you feel and what you do.
CLIENT: Okay.
THERAPIST: What would you think if you texted your best friend 8 hours ago and he didn't text you back?
CLIENT: That maybe there's something wrong.
THERAPIST: How would that thought make you feel?
CLIENT: Worried, I guess.
THERAPIST: And what would you do?
CLIENT: Probably text again, and if I still didn't hear anything, I'd probably call.
THERAPIST: Okay, that's a good example of how your thinking influences how you feel and what you do.

Then, if you want to reinforce the cognitive model, you can provide a different automatic thought, using the same situation. For example, ask what the client would feel and do if she had the thought "He's always doing this to me. He's so rude." Next, ask her to summarize what she's just learned.

CLINICAL TIPS

When clients' cognitive abilities are impaired or limited, you can use more concrete learning aids such as cartoon figures with various expressions to illustrate emotions with empty "thought bubbles" above their heads.

Setting an Action Plan Item to Reinforce the Cognitive Model

Next, I suggest that Abe look for depressed automatic thoughts during the week. I ask him to anticipate an automatic thought and remind himself that it might or might not be true.

JUDITH: Here's something I'd like you to do this week. Notice when your mood is getting worse or when you're not being productive. Then ask

yourself, "What was just going through my mind?"

ABE: Okay.

JUDITH: I wonder if you could predict what one of these thoughts might be?

ABE: It could be almost anything. I could be sitting on the couch, and I could think about doing anything, cleaning the apartment …

JUDITH: That's good. So, let's say you're thinking of cleaning the apartment. How do you think you'll be feeling?

ABE: Probably tired. I'll probably think, "I'm too tired to do anything."

JUDITH: That's a good example. So, the situation is that you're sitting on the couch, thinking of cleaning, and you think, "I'm too tired to do anything." How does this thought make you feel emotionally?

ABE: Depressed.

JUDITH: And if you believe this thought, that you're too tired to do anything, what do you think you'll do?

ABE: Probably just keep sitting.

JUDITH: I think you're probably right. (*pause*) Okay, this week, I'd like you to notice when you're feeling really depressed or not being productive. Then I'd like you to ask yourself, "What was just going through my mind?" (*pause*) Then I'd like you to jot down your thoughts. But then remind yourself that they might not be true, or at least not completely true. Okay?

ABE: I'll try.

JUDITH: You can write your automatic thoughts on this Identifying Automatic Thoughts Worksheet (*pulls out worksheet in Figure 6.2*) or you can use paper or a notebook or your phone. Which would be best?

ABE: I'll try the worksheet.

Remember: Just because I think something doesn't necessarily mean it's true. When I change my unhelpful or inaccurate thoughts, I'll likely feel better.

Instructions: When my mood gets worse or I'm engaging in unhelpful behavior, ask myself, *"What was just going through my mind?"* Write down my thoughts below.

FIGURE 6.2. Identifying Automatic Thoughts Worksheet. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

JUDITH: Good. (*Hands Abe the worksheet.*) You see it has the directions right at the top, the ones I just showed you.
ABE: Okay.
JUDITH: (*Making sure Abe knows what to do.*) Could you write your automatic thought on it—"I'm too tired to do anything"?
ABE: Okay. (*Writes this thought on the worksheet.*)
JUDITH: I wonder if you'll need a reminder? Like a sticky note, or you could move your watch to your other hand or wear a rubber band around your wrist—to remind yourself to look for your automatic thoughts.
ABE: I think I need to see something, some kind of reminder that I can see. A rubber band would be good.
JUDITH: I have one here. Do you want to put it around your wrist now?
ABE: Okay.
JUDITH: (*Hands Abe a rubber band; he puts it on his wrist.*) So, every time you look at the rubber band, what are you going to ask yourself?
ABE: What just went through my mind?
JUDITH: That's right, especially if your mood is getting worse, or you're doing something that's not productive. And you'll remind yourself that the thoughts might not be true.
ABE: Okay.

IDENTIFYING VALUES AND ASPIRATIONS

Eliciting Values

Next, you focus on identifying clients' values. Values are long-standing beliefs about what is most important in life. People's values shape their choices and behavior. But when they perceive they're not living up to their

values, they often become distressed. In a conversational tone, you can ask clients, “What’s really important to you in life? Or what used to be really important to you?”

CLINICAL TIPS

If clients reply that nothing seems important or if they have difficulty formulating a response, you can offer suggestions: “How important is _____ to you?”

You can ask them to consider areas such as the following:

- relationships (family, friends, intimate partner),
- productivity (work outside the home, managing at home),
- health (might also include fitness, eating, sleep, use of alcohol or substances),
- self-improvement (education, skills, culture, appearance, self-control),
- community (locally or more broadly),
- spirituality,
- recreation (entertainment, hobbies, sports),
- creativity,
- nature, and
- relaxation.

Having clients reflect on what’s really important to them aids in identifying their aspirations and setting goals. These interventions can inspire hope, motivate clients to engage in treatment and complete Action Plans, and help them overcome obstacles and problems they face day to day.

JUDITH: Abe, I wonder if we could turn to something else, and that is to talk about what’s really important to you in life. What *are* the most important things to you in life? Or maybe before you got depressed, what was really, really important to you?
ABE: My kids.
JUDITH: Yes.
ABE: Grandkids too.
JUDITH: Your grandkids, okay. What else was really important?
ABE: Well, it was always important to me to work and be productive, but I screwed that up.

I had already reviewed the cognitive model with Abe, and I decide it would be better to let that automatic thought go unaddressed so we can continue identifying values.

JUDITH: What else has been important to you?
ABE: Friends. Sports, I guess. I've always liked sports.
JUDITH: Oh, that's good. Playing or watching or both?
ABE: Both.
JUDITH: Anything else that's been really important to you?
ABE: I don't know. I used to go to church, and I used to do things. I used to volunteer, help people. I liked helping people.
JUDITH: Anything else? How about your health?
ABE: Yeah. I used to eat healthy, exercise—things like that.

Eliciting Aspirations

To elicit clients' aspirations, ask one or more questions such as the following (Beck et al., in press):

> "What do you want for your life?"
> "What are your hopes for the future?"
> "What do you want your future to look like?"
> "When you were growing up, what did you want your life to be like? What did you hope for?"

It's fairly easy to elicit Abe's aspirations.

JUDITH: I know you've been very depressed for quite a while and you're unhappy with your life. (*pause*) What *do* you want for your life?
ABE: I want it to be like it was before I got depressed.
JUDITH: And what was that?
ABE: I want to have a job. I want to have better relationships with my family. And with my friends. (*Thinks.*) I want to take care of myself better. And my apartment.
JUDITH: Anything else?
ABE: (*Thinks.*) I want to feel good about myself. I want to feel useful, helpful.

Drawing Conclusions about Aspirations

It's not clients' aspirations and experiences alone that are important. It's the *meaning* that clients put to them. Help clients draw conclusions about

having achieved their goals and aspirations, especially in terms of improving their life, self-image, sense of purpose and control, and connectedness to others. Ask questions such as these (Beck et al., in press):

> "What would be especially good about [achieving your aspirations and goals]?"
> "How would you feel about yourself? What would it say about you? How might other people view you or how might they treat you differently?"
> "What would it suggest about your future?"
> "How would you feel [emotionally] if all this came true? Can you get that feeling right now?"

I use these questions with Abe.

JUDITH: Abe, if you had a good job, good relationships with your family and your friends, if you were taking better care of yourself and your apartment, if you were helping other people, what would be good about that?
ABE: I'd feel good about myself. I'd be productive.
JUDITH: And what would that show about you as a person?
ABE: I guess it would show I'm a good person, I'm responsible.
JUDITH: Would it show that you were a good worker, a good father, a good grandfather, a good friend?
ABE: Yes.
JUDITH: And how would other people view you?
ABE: I would hope the way they did before. That I'm reliable, I'm hardworking, friendly.
JUDITH: And if all these things happen, what do you think your future would be like?
ABE: Pretty good, I think.
JUDITH: And how would you feel about yourself?
ABE: Much better.

Creating an Image of Having Achieved the Aspirations

Using imagery can make aspirations more concrete and lead to clients' experiencing positive emotion in the session.

JUDITH: Abe, I wonder if you could imagine a day in the future when you've completely recovered from depression, when all these good things have come true? Let's say it's a year from now. Where do you think you'll wake up?

ABE: If I was working and had more money, maybe in a different apartment.

JUDITH: Can you imagine opening your eyes? What does the room look like?

ABE: Umm, a year from now? My bedroom would be bigger. There would be a lot of light in the room. It'd be neat, well organized.

JUDITH: And how are you feeling as you wake up?

ABE: Pretty good.

JUDITH: Looking forward to the day?

ABE: If I had a good job? Then yes.

JUDITH: Can you see yourself getting out of bed? What are you thinking?

ABE: Probably just about what I'm going to do that day.

JUDITH: And how are you feeling?

ABE: Pretty good.

JUDITH: What do you think you'd do next?

I continue to coach Abe in imagining this future day, in detail. As he speaks, I see his affect start to brighten a little.

SETTING GOALS (PART 1)

Having identified clients' values and aspirations, you collaboratively set goals and record them. These goals are more specific than the broad ones you discussed during the evaluation session. Clients with depression benefit from identifying goals in a variety of areas (Ritschel & Sheppard, 2018). You might suggest that they think about goals related to the same areas that were outlined on pages 104–105. Below, Abe and I set some goals. Then we address an automatic thought that gets in the way, before returning to goal setting.

JUDITH: Abe, could we talk about some specific goals you might have? How would you like your life to be different? How would you like to be different?
ABE: I'd like to be the way I used to be, doing all that stuff [we just talked about].
JUDITH: So, you'd like to spend more time your kids and your grandkids?
ABE: Yes.
JUDITH: (*writing it down*) That's a good goal. What else?
ABE: Well, get a good job. But I don't know how I'm going to be able to do these things. I haven't been able to, up to this point.

Addressing Automatic Thoughts That Interfere with Goal Setting

I conceptualized that rather than continuing to set goals, it would be important to respond to Abe's automatic thoughts. I use our discussion to reinforce that

- his thinking may be biased and inaccurate,
- we will work together as a team,
- I have good reason to expect treatment to help, and
- coming to treatment is a sign of strength.

I also ask Abe to commit to making a change in the coming week, even if he has interfering thoughts.

JUDITH: Yes, your depression has made it hard for you to do these things. So, what's different now?

ABE: I don't know.

JUDITH: Hey, Abe, *I'm* here. Do you have a sense that I can help?

ABE: I think maybe you could.

JUDITH: [trying to build hope] Abe, I have to tell you there's *nothing* about you that makes me think that you're *not* going to get over this depression. I really think you are. Should I tell you why I think that?

ABE: Yes.

JUDITH: Okay. So, the first thing is that you were willing to come for an evaluation last week, even though you were skeptical about treatment. But you did a good job on the evaluation. You were able to answer all my questions. We were able to make an Action Plan, especially taking your grandson for ice cream. You were able to do that, even though you thought it would be very hard. So I see that you're willing to try this treatment. And it's fine if you're *still* skeptical about treatment. (*pause*) You'll need to see for yourself that it's working. Okay?

ABE: Yes.

JUDITH: And you're not in this alone. We'll be working as a team to get you better. We'll work on the goals, step by step, so it won't feel overwhelming. And there are skills you need to learn, like answering back your automatic thoughts. You don't know how to do these things yet—I'll need to teach them to you.

ABE: But I've always thought I should solve my problems myself.

JUDITH: Okay. Back to the pneumonia analogy. If you had bacterial pneumonia, would you try to cure yourself?

ABE: No. I'd have to go to the doctor.

JUDITH: And the doctor would help you. (*pause*) I will too. But instead of giving you medication, I'll be teaching you skills to get over your depression. Skills that research shows get people better. (*pause*) Okay?

ABE: I guess so.

JUDITH: You know, I think it's a sign of strength that you're willing to do something that goes against your grain.

ABE: Maybe I am seeing everything through black glasses.

JUDITH: Yes, I think you are. And what we have to do together—note I said "together"—is to scratch off the black paint so you can get over your depression. (*pause*) Should we get back to setting goals?

ABE: Okay.

SETTING GOALS (PART 2)

Having responded to Abe's dysfunctional thinking, we return to goal setting. I make sure to avoid overwhelming Abe with too many goals, and I limit our discussion so we'll have time to get to activity scheduling.

JUDITH: Okay. Do you have other goals?
ABE: I should see my friends more. But they might be annoyed with me, so I don't know if that'll work [automatic thought]. I haven't been in contact with them for a while.

I conceptualize that it's more important to keep setting goals than to respond to this automatic thought.

JUDITH: Should we put that down with a question mark?
ABE: Yes.
JUDITH: Anything else?
ABE: Well, it would be good to clean the apartment.
JUDITH: And how about your physical health?
ABE: Yeah. It would be good to start eating better and exercising.
JUDITH: I think this is a *really* good list. I've written your goals here on the bottom of your Action Plan. Would you be willing to take a look at this list during the week to see whether there are any goals that you want to cross off or add or change? I'm thinking you might want to have a goal of having more fun, doing more pleasurable things, but it's up to you.

Goal List	*May 13*
• *Get a good job*	
• *See friends more?*	
• *Clean the apartment*	
• *Eat better*	
• *Exercise*	

Difficulties in Setting Goals

There are three difficulties that sometimes arise when you're trying to set goals:

1. Clients have difficulty coming up with goals.
2. Clients set goals that are too broad.
3. Clients set goals for other people.

When clients say, "I don't know" to your goal setting questions, you can try a "miracle" question instead. Solution-focused brief therapy (de Shazer, 1988) suggests you ask a question such as the following: "If a miracle happened and you weren't depressed when you woke up tomorrow, what would be different? How would someone know you weren't depressed?" Or you can find out whether clients believe there are disadvantages to setting goals.

Sometimes clients express goals that are too broad (e.g., "I don't want to be depressed anymore" or "I want to be happier" or "I just want everything to be better"). To help them become more specific, you can ask, "If [you weren't depressed anymore/if you were happier/if everything was better], what would you be doing differently?"

Occasionally clients state a goal over which they don't have direct control: "I'd like my partner to be nicer to me"; "I want my boss to stop putting so much pressure on me"; "I want my kids to listen to me." In this case, it's important to help them phrase the goal so it's something they do have control over.

> "I don't want to promise you that we can directly get your sister to be nicer to you. What do you think of phrasing it this way: 'Learn new ways of talking to Erica.' It's possible that if *you* take control and change what *you're* doing, it will have some impact on her."

For a broader discussion of what to do when clients set goals for others, see J. S. Beck (2005).

CLINICAL TIPS

Add new goals to the list as they come up in later sessions. Note that goals are the flip side of problems. For example, if the client says, "I don't know what to do about my teenager," you can say, "Do you want to have a goal to decide what to do?" If the client says, "It's so hard to get everything done," you can say, "Do you want to have a goal to figure out if you can do something to make it easier?"

SCHEDULING ACTIVITIES

If there's time in this first session, it's a good idea to help most depressed clients schedule activities for the coming week and give themselves credit for engaging in these activities. Alternatively, if there's a pressing problem that needs immediate attention, you can work on that. Because Abe has been so inactive, and because he hadn't brought up a more pressing problem, I bring up scheduling activities for the coming week. You'll read about what we did in the next chapter.

END-OF-SESSION SUMMARY

The final summary ties together the threads of the session and reinforces important points. Initially, you'll probably summarize. When you think clients are capable of providing a good summary, you'll ask them to do it.

At the end of the first session, you might say something like this: "I'd like to summarize what we went over about today, so it's clear to both of us. We talked about your diagnosis and how your thoughts influence how you feel and what you do. We identified what's really important to you and what you want for your life. Then we set goals and figured out some activities for you to do this week."

The summary also includes a review of what clients have agreed to do for their Action Plan and an assessment of how likely they are to complete it. You'll read about this in Chapter 8 (pp. 135–159). Figure 6.3 presents Abe's first-session Action Plan. Make sure to give clients the written Action Plan and any other worksheets or notes that they'll need.

Action Plan May 13

Read this Action Plan and the one from last week twice a day.

Continue to give myself credit.

How my thoughts affect my reaction

Situation: Thinking about doing something, like taking grandchildren out

↓

Automatic thoughts: "Everything is too hard."

↙ ↘

Emotion: Depressed Behavior: Stay sitting on couch

When I criticize myself, remember I'm only looking at part of the scene, and it's through black glasses. Judy says it's not my fault that I'm doing this. It's happening because I have depression.

When I notice my mood is getting worse or I'm doing something unproductive, ask myself, "What's going through my mind right now?" and write down my thoughts on the Identifying Thoughts Worksheet. Wear a rubber band to remind me to do this.

Remember, black glasses →

If I'm feeling really tired and feel like staying on the couch instead of going out—or doing something else—remind myself that I have to get back into the world. It's important to go. Not going will probably keep me depressed. I want to get back into the world so I can be productive, be better to my family. I'll feel more useful and competent and in control. Going out may or may not affect my mood right away. I may need to crank up the jack-in-the-box.

To do:

1. Take Ethan out for ice cream.
2. Go out four times this week. For example, take a 5-minute walk, go to the grocery store, or go to the hardware store. Demonstrate to myself that I can take control and do things.
3. Look at the goal list. Do I want to add or cross off or change any?

FIGURE 6.3. Abe's Session 1 Action Plan.

FEEDBACK

The final element of the first session is feedback. By the end of this session, most clients feel positive about the therapist and the therapy. Eliciting feedback further strengthens rapport, providing the message that

you care about what the client thinks. It also gives clients a chance to express, and you to resolve, any misunderstandings. Clients may occasionally make an idiosyncratic (negative) interpretation of something you said or did. Asking them whether there was anything that bothered them gives them the opportunity to state and then test their conclusions. In addition to verbal feedback, it's a good idea to ask clients to complete a written Feedback Form (Figure 6.4).

Name _____ Date _____

What do you want to remember from the therapy session today?

Was there anything that bothered you about the therapist or about therapy? If so, what was it?

How likely are you to do the new Action Plan? How is it related to your aspirations and values? If you do it, what will that show you (especially about yourself)?

What do you want to make sure to cover next session?

FIGURE 6.4. Feedback Form. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

JUDITH: Abe, can you give me some feedback about this session, [providing rationale] so I can make changes for our next session if I need to? (*pause*) What did you think of it? Was there anything that bothered you or anything you thought I didn't understand?

ABE: No, it was good.

JUDITH: Is there anything you think we should do differently next time?

ABE: No, I don't think so.

JUDITH: If you did have any negative feedback, do you think you could tell me?

ABE: I think so.

JUDITH: If you do, the first thing I'll say is "It's good you told me that." If there's something I'm doing that's not right, I want to know, so I can fix it. In fact, you'll have another chance to tell me. Can I give you this Feedback Form to fill out in the reception area? You can give it to [the receptionist], and he'll give it to me. It will help you think about the session and whether there's anything I should know.

ABE: Okay.

JUDITH: That's good. Well, I'm so glad that you came in today. Is this time good for you next week?

ABE: Yes.

JUDITH: I'll see you then.

REFLECTION QUESTION

Why is it important to help clients identify their values, aspirations, and goals?

PRACTICE EXERCISE

Ask yourself the relevant questions in this chapter to identify your own values and aspirations. Then identify at least one goal and write down one or two steps you can take this week toward achieving it.

7

ACTIVITY SCHEDULING

One of the most important initial steps for depressed clients is scheduling activities (Cuijpers et al., 2007). Most have withdrawn from and are actively avoiding at least some activities that had previously given them a sense of achievement, control, pleasure, or connection—and that lifted their mood. Many stop following their daily routine and do less self-care. Like Abe, they eat less well, exercise less often (if at all), and sleep too much or too little. They frequently increase certain behaviors such as staying in bed, watching television, playing video games, looking at social media, or surfing the internet. This change in activities helps maintain or increase their current dysphoria and the sense that they're at least somewhat out of control. We get across the following messages:

> "It's important to act according to your *values*, what's really important to you, instead of what you *feel* like doing—because depression makes you tired and then you'll feel like avoiding. But avoidance just makes depression worse. Don't wait until you feel energetic or motivated to start an activity or task. Do it first. You'll probably find that you get more energized and motivated some time *after* you start.
>
> "As you're engaged in an activity, watch out for negative thoughts that can decrease your sense of competence, purpose, and connection to others. Because you're depressed, at least some of these thoughts are likely to be inaccurate, or at least partially inaccurate. When you're finished the task or activity, make sure to give yourself credit

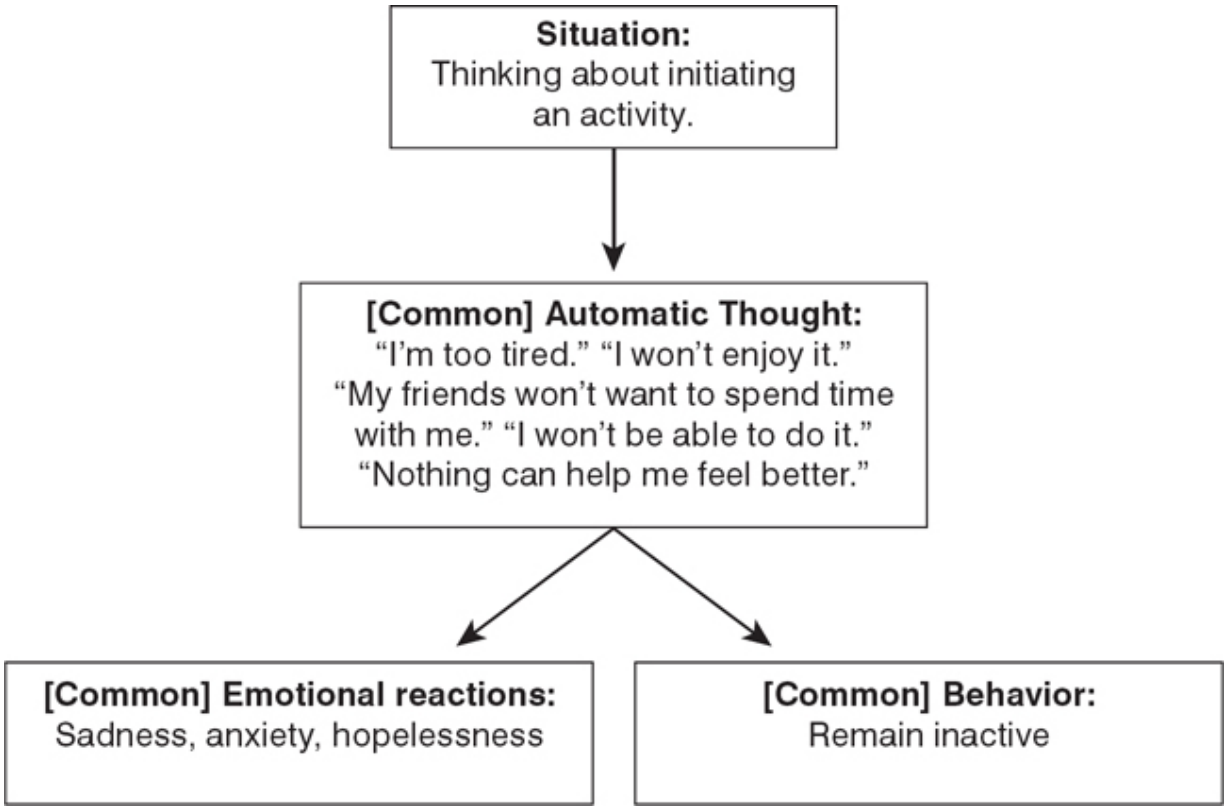
—you can just say something like ‘good.’ Recognize that pushing yourself to do something means you’re taking control, even if in a small way, of your depression.”

Clients often believe they can’t change how they feel emotionally. Helping them become more active and giving themselves credit for their efforts are essential parts of treatment. Doing so improves their mood and strengthens their sense of self-efficacy—they demonstrate to themselves that they can take more control of their mood and behavior than they had previously believed. We usually start collaboratively scheduling activities in the first or second therapy session. In this chapter, you’ll find answers to these questions:

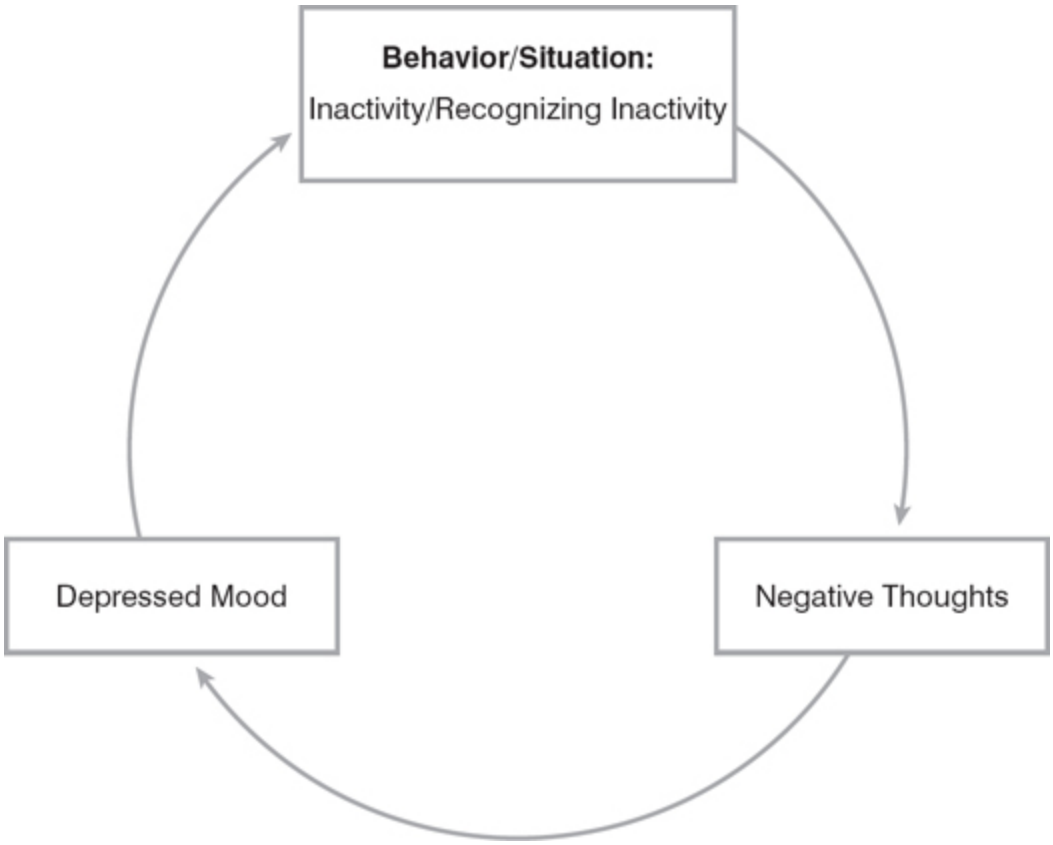
- How do you conceptualize inactivity?
- How do you conceptualize lack of mastery and pleasure?
- How do you schedule activities with clients?
- How do you use an Activity Chart?
- How do you help clients track and rate their activities?
- What types of activities should depressed clients engage in?
- How do you use an Activity Chart to assess predictions?

CONCEPTUALIZATION OF INACTIVITY

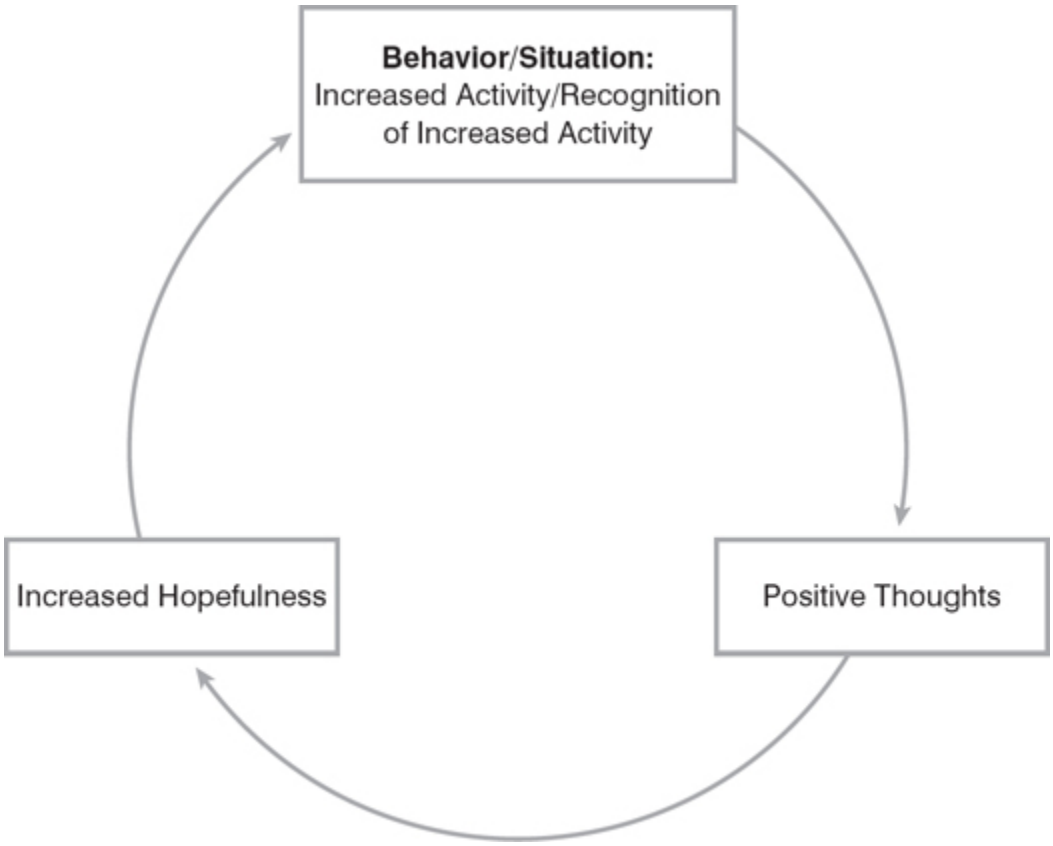
When considering engaging in activities, clients’ depressed automatic thoughts frequently get in the way.


Situation:
Thinking about initiating an activity.
[Common] Automatic Thought:
"I'm too tired." "I won't enjoy it."
"My friends won't want to spend time with me." "I won't be able to do it."
"Nothing can help me feel better."
[Common] Emotional reactions:
Sadness, anxiety, hopelessness
[Common] Behavior:
Remain inactive

Clients' relative inactivity then contributes to their low mood, as they have a paucity of opportunities to gain a sense of mastery, pleasure, or connection, which leads to more negative thinking, which leads to increased dysphoria and inactivity, in a vicious cycle.



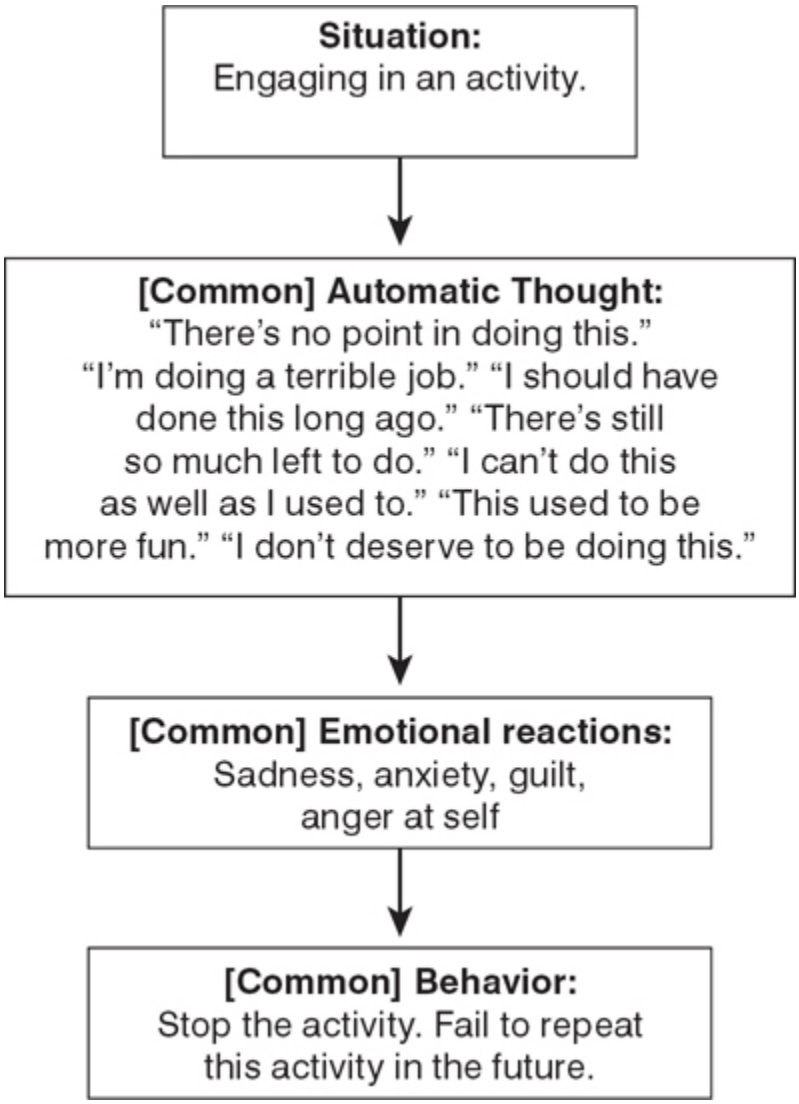
On the other hand, becoming more active and recognizing that they deserve credit usually lifts their mood and makes it easier to continue being more active.



If you think it would be helpful, you can draw these diagrams for clients and add them to their Action Plans to review at home.

CONCEPTUALIZATION OF LACK OF MASTERY OR PLEASURE

Even when clients do engage in various activities, they often derive low levels of satisfaction and pleasure because of their self-critical automatic thoughts.


Situation:
Engaging in an activity.
[Common] Automatic Thought:
"There's no point in doing this."
"I'm doing a terrible job." "I should have done this long ago." "There's still so much left to do." "I can't do this as well as I used to." "This used to be more fun." "I don't deserve to be doing this."
[Common] Emotional reactions:
Sadness, anxiety, guilt, anger at self
[Common] Behavior:
Stop the activity. Fail to repeat this activity in the future.

Clients may also have similar negative thoughts *after* engaging in an activity ("I should have done that better"; "Doing that was just a drop in the bucket"). When scheduling activities, therefore, it's important to anticipate automatic thoughts that could interfere with clients' initiation or continuation of activities and thoughts that could diminish their sense of pleasure, achievement, or connection during or after the activity.

SCHEDULING ACTIVITIES

Most clients who are depressed have changed their daily or weekly activities to some degree. It's important to help them reengage more fully in life. Some therapists ask depressed clients to fill out an Activity Chart (Figure 7.1) early in treatment, noting the activities they do each hour and, if they're willing, rating their sense of mastery and pleasure.

Activity Chart, Side One

Name: *Eric L.* Date: *October 24*

Aspirations, values, or goals: *Be a better father, husband. Work in the music business. Take better care of my physical and mental health. Find a spiritual home. Get involved in the community.*

See reverse side for optional rating scales.

		MON.	TUE.	WED.	THU.	FRI.	SAT.	SUN.
Morning	6:00–7:00 A.M.	*Sleep*						
	7:00–8:00 A.M.							
	8:00–9:00 A.M.							
	9:00–10:00 A.M.	*Doze off and on—2*						
	10:00–11:00 A.M.	*Get up/shower/dress—3*						
	11:00 A.M.–12:00 P.M.	*Breakfast, kitchen cleanup (10 min)—3*						
Afternoon	12:00–1:00 P.M.	*TV/computer/video games—2*						
	1:00–2:00 P.M.	*TV/computer/video games—2*						
	2:00–3:00 P.M.	*Nap—2*						
	3:00–4:00 P.M.	*Lunch, kitchen cleanup (10 min)—3*						
	4:00–5:00 P.M.	*Call Natasha—6 Laundry (10 min)—4*						
	5:00–6:00 P.M.	*Errands or take a walk—5*						
Evening	6:00–7:00 P.M.	*TV/computer/video games—2 Laundry (10 mins)—3*						

	MON.	TUE.	WED.	THU.	FRI.	SAT.	SUN.
7:00–8:00 P.M.	*Dinner, kitchen cleanup (10 min)—3*						
8:00–9:00 P.M.	*Walk around mall—4*						
9:00–10:00 P.M.	*TV/computer/video games —2*						
10:00–11:00 P.M.	*TV/computer/video games —2*						
11:00 P.M.–12:00 A.M.	*Get in bed, try to sleep—2*						
12:00–1:00 A.M.	*Sleep*						

FIGURE 7.1. Partially completed Activity Chart, side 1: Tracking and rating activities. Overall mood ratings on a 0–10 scale.

Then they use the information to guide clients in scheduling activities. But not all clients are willing to fill out the chart. And I prefer to have them schedule activities even at the evaluation. That's why I ask them to describe their activities on a typical day, which gives me enough information to discover which kinds of activities they have been avoiding. Ideally, you'd have enough time in the evaluation and first session to elicit potential activities from clients. If there's not enough time, you can suggest activities that are in line with your client's aspirations and values. In subsequent sessions, you might do a combination of suggesting and eliciting ideas.

Here's what I discuss with Abe in our first therapy session.

JUDITH: [being collaborative] Could we talk about how you've been spending your time? Are you still sitting on the couch, watching TV, or using your computer a lot?

ABE: Yeah, too much.

JUDITH: [collecting data to motivate Abe] What's your mood usually like after you've done that for a couple of hours?

ABE: (*Thinks.*) Pretty bad, I guess. I always feel like I should have been doing something more productive.

JUDITH: Can we talk about some other things you might be able to do this week? I think it'll be an important step in taking control.

ABE: Okay.

JUDITH: [providing the rationale] First, you should know that research shows that if you want to get over depression, you need to become more active. We don't have a lot of time today, but I wonder if you could think of some things you could do this week.

ABE: I'm not sure. [expressing an automatic thought that could be an obstacle] I'm pretty tired most of the time.

JUDITH: Would you be willing to try some things as an experiment? To see whether you're actually *too* tired?

ABE: Yeah.

JUDITH: For example, what would you think of trying to get out of your apartment, even if just for a few minutes, most days this week?

ABE: I guess I could do that.

JUDITH: You could take a 5-minute walk. Or you could go someplace in the car.

ABE: Okay.

JUDITH: [making the step more specific] Where could you go?

ABE: (*Thinks, sighs.*) Well, I have to go to the grocery store today.

JUDITH: That's good. How about the other days?

ABE: I suppose I could go to the hardware store. I have to get some light bulbs.

JUDITH: That sounds good. Could you go to other places even if you don't need anything? The important thing is to demonstrate to yourself that you can start to take more control of your life, that even though you're tired, you can start reengaging with the world.

ABE: Yeah. I understand.

Next, I want to make sure that Abe is prepared for the possibility that getting out doesn't make him feel better. I also reinforce the cognitive model.

JUDITH: Now, I don't know whether getting out will affect your mood or not. It will depend on what you're thinking. If you think, "What's the point of doing this?" or "This is just a drop in the bucket," how do you think you'll feel?

ABE: Depressed.

JUDITH: I think you're right. And if you think, "Hey, this is really good. Even though I'm tired, I'm taking control. It's a really important step,"

then how do you think you'd feel?

ABE: Better.

JUDITH: Okay. But I don't want to promise you that getting out will definitely improve your mood. Some people *do* feel better right away. But for others, it's like a jack-in-the-box; you know, that toy that you wind up (*motions with a circular hand movement*) and the clown pops out?

ABE: Yeah. My kids had one.

JUDITH: Some people can crank the level only once and the clown pops out —they feel better. Other people need to crank it around and around and around. It can take weeks for the clown to pop out and for them to feel better. But you have to start someplace.

ABE: Should I get out of the apartment every day?

I don't want to set an Action Plan item that Abe might have difficulty with (and then blame himself), so I propose a range.

JUDITH: Maybe we should say four times this week? So, four times is great, and if you do more than that, so much the better.

ABE: Okay.

JUDITH: Should I write this down, or do you want to?

ABE: You can.

JUDITH: (*Writes it down on Abe's Action Plan.*)

Next, I elicit the rationale from Abe and help him respond to automatic thoughts that could pose an obstacle to taking these steps by tying these activities to his aspirations and values.

JUDITH: Now let's write down *why* it would be good to do this.

ABE: You said it's a first step, to take control.

JUDITH: Exactly. (*Writes that down; then looks for potential obstacles.*) Now, what could get in the way?

ABE: (*Sighs.*) If I'm too tired.

JUDITH: You might be really tired. What would you like to say to yourself if you're feeling really tired? [I ask this question because I sense that Abe would have a good response. With other clients, Socratic questioning might have been important.]

ABE: I guess, "Go anyway"?

JUDITH: Good. Go anyway because …
ABE: Because I need to get back in the world.
JUDITH: How important is it to you to get back in the world?
ABE: Very important.
JUDITH: [eliciting his values and aspirations] Why is it important?
ABE: So I can get back to work. So I'll feel useful. So I can be productive.
JUDITH: Anything else?
ABE: Yeah, so I can be a better father and grandfather.
JUDITH: Should we write something down about this too? "If I'm feeling really tired and feel like staying on the couch instead of going out—or, I suppose, doing something else—remind myself …
ABE: I have to get back in the world. It's important to go. Not going will probably keep me depressed.
JUDITH: And you want to get back in the world so you can …
ABE: Be productive, be better to my family.
JUDITH: When you're back in the world, will you feel more useful and competent? In control? Have a sense of purpose?
ABE: Yeah, all those things.
JUDITH: That's good. Let me get that down on your Action Plan. (*pause*) And should we add that going out may or may not affect your mood right away? And if it doesn't, it just means you need to crank up the jack-in-the-box?
ABE: Yeah.
JUDITH: (*Writes it down.*) Now how likely are you to get out of your apartment—even if it's just for a 5-minute walk or a fast trip to a store—at least four times this week?
ABE: I'll definitely do that.
JUDITH: Okay! Now, if you find you just can't, that's all right. It just means we probably need to start with something easier. But do try to keep track of the thoughts that get in the way.
ABE: Okay.
JUDITH: I'll add that to the Action Plan too. (*Does so.*)

CLINICAL TIPS

If the discussion above isn't persuasive, you can try the following, as I did with Maria.

When Clients Resist Scheduling Activities

When I tried to schedule activities with Maria in the first session, she didn't want to commit to anything specific. I thought pressing the point would impair the therapeutic relationship, so we agreed that she would try to become more active in general. During our review of the Action Plan in the following session, it turns out that Maria hasn't been able to be more active, so we add that goal to the agenda. I start off by reminding her of the rationale for activity scheduling.

JUDITH: Is it okay if we talk about scheduling some activities this week?
MARIA: Okay.
JUDITH: Do you remember what we said last week about why that's important?
MARIA: Not entirely.
JUDITH: First, research show that an essential part of getting over depression is becoming more active. Second, it doesn't sound as if there's much you're currently able to do that brings you much pleasure or helps you feel competent and effective and in control. Is that right?
MARIA: I guess not.
JUDITH: You know, most people who are depressed think they'll feel better if they stay in bed. Can I ask you this? Haven't you already done the experiment of staying in bed, actually for months and months? Has it helped you recover from your depression? [referring to Maria's aspirations] Has it helped you get to where you want to be in life—having more friends, working and earning money, having a better apartment, finding a romantic relationship …?
MARIA: No, it hasn't.
JUDITH: And if you keep staying in bed, do you think it will suddenly work?
MARIA: I suppose not.
JUDITH: Would you like to try a different experiment this week?
MARIA: (*Sighs.*) I guess so.
JUDITH: We could talk about activities you feel you could do that would be either meaningful or easy. Which do you think would be better?
MARIA: Maybe both?
JUDITH: Good idea. Okay, here are some categories: self-care, like showering, getting dressed, eating well, and getting exercise. Another category is connecting with people. A third category is managing

better at home. A fourth category is recreation or entertainment. So that's self-care, connecting with people, managing better, and recreation/entertainment. (*pause*) Which category do you think would be easy and also meaningful?

MARIA: I don't see how scheduling activities will help. (*a little angrily*) My whole *life* is a disaster.

JUDITH: It's good you told me that. I probably should have explained some more. You're absolutely right. You have big problems that you need help in solving. But here's what I've found. When people are as depressed as you are, trying to solve really big problems becomes overwhelming. That's why it's better to start with small things and build up your confidence by showing you that you can take control of parts of your life and that you can be effective. That's why the small steps are important.

MARIA: (*Sighs.*) Oh.

Next, I remind Maria about her aspirations and how achieving those aspirations would make her feel good and change her view of herself and how others viewed her. We also make a chart showing her how her actions could make her mood better or worse:

Things that make me feel better	*Things that make me feel worse*
Meeting up with friends *Looking for things to do with friends (concerts, etc.)* *Baking* *Looking at photographs* *Working on my scrapbook* *Having a clean apartment* *Calling Hillary* *Doing a crafts project* *Planning a trip*	*Staying in bed* *Taking long naps* *Watching too much TV* *Sitting around (not being productive)* *Staying on phone with Mom when she's mad* *Dwelling on the past* *Drinking too much* *Listening to sad songs*

Then she is more motivated to continue with activity scheduling.

JUDITH: Can I review the four categories again? Self-care, connecting with others, managing at home, and fun. Do you want to pick a category?

MARIA: Managing better at home, I guess.

JUDITH: Good. What are three things you could do this week that would be meaningful and relatively easy?

MARIA: I'm not sure. I don't know if I have the energy to do any more than I'm already doing.
JUDITH: Would you be willing to try some things as an experiment? To see whether you might possibly have more energy than you predict?
MARIA: Yeah, I guess so.
JUDITH: Okay, so three things that wouldn't be overly tiring?
MARIA: I could throw out the newspapers and take the trash out.
JUDITH: Good. What else?
MARIA: Change the sheets on my bed.
JUDITH: Good. What else?
MARIA: (*Thinks.*) Throw out some food from the refrigerator.
JUDITH: All good things. What would it mean if you can do those things?
MARIA: I'm not sure.
JUDITH: Might it mean that you can do things even if you're tired? That you can start to take control of your life? That you can take steps toward getting a better life?
MARIA: Yes. I think so.
JUDITH: Can we write some of this down on your Action Plan?

Next, Maria and I talk about obstacles that could get in her way or that could interfere with her feeling good about doing these activities. We discuss unhelpful thoughts she might have before, during, and after the activities. We review the importance of giving herself credit and set up a reminder system. We also discuss how she would feel when she accomplished these tasks and what that would signify about herself and her future. Finally, we make this a no-lose proposition: Either she would do the activities or she would keep track of the thoughts or practical problems that got in the way.

USING AN ACTIVITY CHART

Some clients, like Abe, are likely to follow through with activities they committed to in session without discussing precisely when to do them. Other clients benefit from committing to do certain activities on certain days at certain times. You and the client can collaboratively schedule these

activities on their Action Plan or using an Activity Chart (Figure 7.1). Make sure to help clients list their aspirations at the top of the chart to help motivate them.

It's useful for some clients to use the Activity Chart to collaboratively plan an entire day, hour by hour. Clients can use this schedule as a template, making a more specific schedule each morning or previous evening. Make sure that the schedule is on the easy side, especially when clients are more severely depressed. It's unreasonable to expect that they can go from being almost completely inactive to being active every hour of the day. They may need to schedule periods of relative inactivity interspersed with activities that require more effort.

RATING ACTIVITIES

When clients use the Activity Chart to schedule activities, they can later use the same chart to circle or check off which of the activities they had actually completed. Some clients are willing to fill in the Activity Chart with *all* their activities, prescheduled or not. You'll collect a lot of important data if clients are willing to rate how much of a sense of pleasure and/or mastery they got from each activity. Or they can just rate their overall mood during the activity on a scale of 0–10. Clients can create scales with their own sample activities at anchor points such as 1, 5, and 10 or 2, 5, and 8. (See Figure 7.2 for two kinds of rating scales.)

Activity Chart Rating Scales

Name: *Eric L.* Date: *October 24*

Directions (optional): Use either the top or bottom scale and fill in activities.

	PLEASURE	**MASTERY**
0	*Arguing with partner*	*Thinking about my credit card debt*
5	*Watching hockey on TV*	*Raking leaves last year*
10	*Finding out about my promotion*	*Finishing the 5K race*

	OVERALL RATING SCALE

	OVERALL RATING SCALE	
0	*Very distressed/depressed*	*When my girlfriend broke up with me*
5	*Neutral mood*	*Running errands*
10	*Feeling great*	*Going to a football game*

FIGURE 7.2. Activity Chart, side 2: Rating scales.

When people are depressed, their memories are often more negative than their actual experience. They may believe that an entire day or week was bad. Doing ratings immediately after an activity (or at lunch, dinner, and bedtime) helps them recognize the parts that were better. And it allows the two of you to figure out whether they need to schedule more pleasure, mastery, social, or self-care activities—and whether to decrease other activities.

But here's a caveat. Some clients dislike rating scales. Others may lack the motivation to track their experiences. Make sure clients are highly likely to rate their activities—if not, it may be better to make the ratings optional. On the other hand, clients who tend to be organized and detail oriented may be willing to keep track of all their activities during the week *and* rate them.

TYPES OF ACTIVITIES

If you don't know which activities to suggest to clients, you can review their typical day (pp. 121–123). Then ask yourself these questions:

"Given my client's aspirations …

- Which activities is the client doing too much of?
- Which activities is she doing too little of or avoiding altogether?
- Does he have a good balance of mastery, pleasure, self-care, and social experiences?
- What can she do that will be meaningful and lead to positive emotion, connection, and empowerment?

What can he do that will help him draw positive conclusions, especially about himself?"

Also ask yourself, "Which new activities is the client most likely to engage in?"

When relevant, you can suggest that clients search online for pleasurable activities or hobbies or interview other people to find out what they do. When appropriate, you might suggest engaging in some activities with family members, friends, neighbors, or others in the community. In any case, when reviewing their Action Plans in subsequent sessions, make sure to help clients draw conclusions about these experiences and especially what it means about them that they did these things. In the next chapter, you'll read more about setting and reviewing Action Plans and what to do when clients have difficulty following through with Action Plans.

CLINICAL TIPS

When Clients Have a Problematic Behavior or Habit

Clients who binge eat, smoke, use substances, overspend, gamble, or act angrily or aggressively might record all their activities to investigate patterns of occurrence, or they might just record the occurrence of maladaptive behaviors.

USING THE ACTIVITY CHART TO ASSESS PREDICTIONS

When clients are skeptical that scheduling activities can help, you can ask them to *predict* levels of mastery and pleasure and connection, or what their overall mood will be on an Activity Chart and then record their *actual* ratings. These comparisons can be a useful source of data. If they find their predictions are inaccurate, they usually become more motivated to continue scheduling activities. If their predictions turn out to be accurate, you'll ask questions to conceptualize the problem, and then likely do problem solving and respond to unhelpful thinking.

JUDITH: Can we take a look at your predictions on the Activity Chart and what actually *happened*?

MARIA: (*Nods*.)

JUDITH: (*Looks at the first chart*.) Let's see … It looks as if you predicted very low scores, mostly 0's and 1's for the three times you scheduled to meet your friends, but you actually rated your pleasure and sense of connection as 4's and 5's. (*pause*) What do you make of that?

MARIA: I guess I was wrong. I thought I wouldn't enjoy myself, but I did, at least some.

JUDITH: What do you think it says about you that you were willing to get together with your friends even though you predicted you wouldn't have a good time?

MARIA: I guess it shows I'm willing to give things a try.

JUDITH: Absolutely! That's such a good sign. (*pause*) Would you like to schedule more social activities for this coming week?

MARIA: Yeah.

JUDITH: Good. Do you see what could have happened—and, in fact, what was happening before you came to therapy? You kept predicting that you'd have a bad time with your friends so you didn't make any plans. In fact, you turned down their invitations. It sounds as if this Action Plan helped you test your ideas. You found it was wrong that you'd have a bad time, and now it sounds as if you're more willing to schedule more. Is that right?

MARIA: Yes. But that reminds me, I wanted to talk about one prediction that actually turned out worse.

JUDITH: Okay, when was that?

MARIA: I predicted that I'd get a 5 in pleasure when I went to the community garden over the weekend. But I got a 2.

JUDITH: Do you have any idea why?

MARIA: Not really.

JUDITH: How were you feeling when you were at the garden?

MARIA: Kind of sad.

JUDITH: What was going through your mind?

MARIA: I don't know. I mean, going to the garden used to be one of my favorite things to do. But I didn't enjoy it. I just felt tired.

JUDITH: Did you have thoughts like that—"Going to the garden used to be one of my favorites. I'm not enjoying this. I'm so tired"?

MARIA: Yeah, I think so.
JUDITH: Anything else go through your mind?
MARIA: I remembered this time when I went with my ex-boyfriend. It was soon after we met. I was so hopeful about our relationship.
JUDITH: Did you have a picture in your mind of that occasion?
MARIA: Yeah. We were walking around, holding hands. I was telling him the names of all the flowers I knew. But he eventually broke up with me.
JUDITH: Okay, let me see if I understand. [summarizing] Here in my office you thought you'd get a moderate sense of pleasure when you went to the garden. But, instead, you got very little. It sounds as if you were thinking of how it used to be and then you had some negative thoughts like "Going to the garden used to be one of my favorites; I'm not enjoying this; I'm so tired." And you also had an image in your mind of a specific time when you first went there with Roger but then you remembered he broke up with you. And these thoughts and the memory made you feel sad. (*pause*) Does that sound right?
MARIA: Yeah.
In this last part, I use the Activity Chart to identify automatic thoughts that are undermining Maria's enjoyment of an activity. Next, we come up with responses to these thoughts and to the memory so she can enjoy the garden more in the future.

CLINICAL TIPS

When Clients Aren't in the Moment

It's important for clients to give their full attention to the activity they're engaged in. If they engage in depressive rumination or obsessive thinking, mindfulness (Chapter 16) can help them let the thoughts come and go as they focus their attention on their immediate experience.

SUMMARY

Scheduling activities is essential for most depressed clients. Many clients need a rationale, a reminder of their aspirations, guidance in selecting and scheduling activities, instruction in how to focus their attention fully on

the experience (and how to bring their focus back to it when their mind strays), and responses to predicted automatic thoughts that might interfere with initiating activities or gaining a sense of pleasure, mastery, or connection. Therapists often need to be gently persistent in helping clients become more active. Clients who are quite inactive initially benefit from learning how to create and adhere to a daily schedule with increasing degrees of activity. Clients who are skeptical about scheduling activities may benefit from doing behavioral experiments to test their ideas and/or checking the accuracy of their automatic thoughts by comparing their predictions to what actually occurs.

REFLECTION QUESTIONS

Why is scheduling activities so important for most clients with depression? How might you conceptualize a client's relative inactivity and lack of mastery or pleasure?

PRACTICE EXERCISE

Using an Activity Chart, schedule for the coming week some worthwhile activities, in line with your aspirations, that you might have difficulty committing to. Create scales to predict the sense of pleasure, mastery, and/or connection you'll get from doing each activity. Use the same scales to write your actual ratings after engaging in these activities.

8

ACTION PLANS

Action Plans (traditionally labeled as "homework") should be considered an integral, not optional, part of CBT (Beck et al., 1979; Kazantzis et al., 2018; Tompkins, 2004). Remember what we tell clients in the evaluation or first session:

> The way people get better is to make small changes in their behavior and thinking every day.

In every session, clients need to learn new ways of thinking and acting that they'll practice at home. Researchers have found that CBT clients who carry out Action Plans progress significantly better in therapy than those who don't (see, e.g., Callan et al., 2019; Kazantzis et al., 2016).

It's very important that clients experience (and recognize their) success and learn from every Action Plan item. When they do, therapy progresses more quickly and clients have an increased sense of hope, mastery, self-efficacy, and control, and their mood and symptoms improve. When they aren't successful, they often become self-critical or hopeless. This chapter answers the following questions:

- How do you set Action Plans?
- What are various kinds of Action Plan items?
- How do you encourage clients to set their own Action Plans?

How do you increase the likelihood that clients will successfully complete their Action Plans?

How can you anticipate and prevent problems in adherence?

How can you prepare clients for a potential negative outcome?

How do you review Action Plans at the next session?

How do you conceptualize and solve problems around completing Action Plans?

What kind of beliefs can interfere with completing Action Plans?

What unhelpful cognitions might therapists have?

SETTING ACTION PLANS

There is no set formula for assigning Action Plans. How do you and the client decide what would be good for the client to do? It depends on your conceptualization, the client's aspirations, what you have discussed in the session (which is influenced by your overall treatment plan and the client's goals), what you and the client think will help most, and very importantly, what the client is willing and able to do. The more depressed clients are feeling at the beginning of treatment, the more their Action Plans should initially emphasize changing behavior (e.g., through activity scheduling). The initial cognitive work often involves modifying automatic thoughts that could interfere with carrying out behavioral Action Plans or gaining a sense of achievement, pleasure, or connection from engaging in the planned activities. As their symptoms improve, you'll add in an additional emphasis on cognitive change.

Good Action Plans provide opportunities for clients to

- draw positive conclusions about their experiences and about themselves,
- educate themselves (e.g., through bibliotherapy),
- collect data (e.g., through monitoring their thoughts, feelings, and behavior),
- evaluate and modify (or disengage from) their cognitions,
- practice cognitive and behavioral skills, and
- experiment with new behaviors.

TYPES OF ACTION PLAN ITEMS

In addition to scheduling activities, many Action Plans contain the following ongoing activities:

1. ***Reading therapy notes.*** After you've discussed an issue or problem, you'll ask clients to summarize or report on what they think is most important for them to remember and to do (pp. 261–264). You'll often suggest additional ideas to make their therapy notes more robust.

2. ***Monitoring automatic thoughts.*** From the first session forward, you'll encourage clients to ask themselves, "What's going through my mind right now?" when they notice their mood is changing or they're engaging in unhelpful behavior. You'll also ask them to remind themselves that their thinking may be true or not true or not completely true. They may jot down their thoughts (in their smartphone, on their computer, or simply on paper, in a notebook, on an index card, or on a worksheet).

3. ***Evaluating and responding to automatic thoughts.*** At virtually every session, you'll help clients modify their inaccurate or unhelpful thoughts, especially those that interfere with carrying out their Action Plans. You'll also teach clients to evaluate their thinking on their own.

4. ***Doing behavioral experiments.*** To test the validity of negative predictions, it's often important to collaboratively design experiments that clients can conduct between sessions (or in session). Using Socratic questioning first is often useful, but actually disconfirming predictions out in the world through personal experience usually results in significantly greater cognitive and emotional change (Bennett-Levy et al., 2004).

5. ***Disengaging from thoughts*** that are part of an unhelpful thought process (self-criticism, rumination, obsessive thinking, or frequent intrusive thoughts). You might teach clients mindfulness techniques to practice between sessions.

6. ***Implementing steps toward their goals.*** You'll ask clients about their goals for each session and collaboratively decide what steps the client wants to take in the coming week. You'll also identify obstacles to taking

these steps and do cognitive restructuring for potentially interfering cognitions and/or problem solving, and/or skills training.

7. ***Engaging in activities to lift affect.*** These activities are usually closely tied to clients' aspirations, values, and goals, and often promote self-care, social interaction, better management (at home and/or work), and/or a sense of pleasure, mastery, or purpose.

8. ***Credit lists.*** Ideally, clients mentally praise themselves and keep a running written list throughout the day of anything they do that's even a little difficult, but they do it anyway. This task is especially important when clients are self-critical or have core beliefs of incompetence or helplessness. A good rationale for the task is that it helps people regain confidence in themselves and see themselves more realistically. If you give yourself credit throughout the day (as I do), you can use self-disclosure to motivate clients to do the same.

9. ***Practicing behavioral skills.*** To effectively solve their problems, clients may need to learn new skills, which they'll practice as part of their Action Plan. For example, you might teach mindfulness or relaxation, emotional regulation, communication, or organizational, time management, or budgeting skills.

10. ***Engaging in bibliotherapy.*** You can greatly reinforce important concepts you've discussed in session when clients read about them between sessions. Many clients benefit from reading a few pages in a CBT book for consumers on depression (*www.abct.org/SHBooks*) or a booklet (J. S. Beck, 2020). These can reinforce important ideas you've reviewed in session. Ask clients to make mental or written notes as they read: What do they agree with? Disagree with? What questions do they have? Be careful when suggesting this Action Plan item though. Consider a client's level of concentration and motivation in suggesting what and how much to read. If they try to read and can't comprehend the material, they may become quite self-critical or fear your criticism.

11. ***Preparing for the next therapy session.*** The beginning part of each therapy session can be greatly speeded up if clients think about what will be important to tell you before they enter your office. The Preparing for Therapy Worksheet (Figure 10.3, p. 178) can help prepare them.

ENCOURAGING CLIENTS TO SET ACTION PLANS

At the beginning of treatment, you may need to suggest Action Plan items; clients don't usually know what would be beneficial for them to do. As therapy progresses, encourage clients to set their own Action Plans.

> "What would you like to do this week [about this issue or to get closer to reaching your goal]?"
>
> "What could you do if you start getting uncomfortably anxious?"
>
> "How will you handle [this obstacle] if it does arise?"

Clients who routinely set their own Action Plans are more likely to continue doing so when treatment has ended.

INCREASING ACTION PLAN ADHERENCE

Many clients do Action Plans quite willingly and easily; some do not. Even the most experienced therapists encounter difficulty with an occasional client. Nevertheless, you should initially assume that any client (unless he or she is very low functioning) *will* do Action Plans if you set them up properly. Here are some guidelines to follow:

- Tailor Action Plans to the individual.
- Provide or elicit the rationale.
- Set Action Plans collaboratively; seek the client's input and agreement.
- Make Action Plans easier rather than harder.
- Provide explicit instructions.
- Set up a reminder system.
- Begin the Action Plan (when possible) in session.
- Ask clients to imagine completing an Action Plan.

Tailor Action Plans to the Individual

Action Plans shouldn't be one size fits all. You and your clients will collaboratively decide what a given Action Plan item should be. When suggesting an assignment, take your client's individual characteristics into consideration:

- Their aspirations, goals, strengths, and personal assets
- Their reading, writing, and intellectual abilities
- Their preferences
- Their level of motivation
- Their current level of distress, symptoms, executive functioning, and general functioning (cognitive, emotional, behavioral, and social)
- Practical constraints (e.g., time, opportunity, and lack of cooperation by family members)

Abe, for the most part, was a motivated client who was willing to work hard to overcome his depression. Initially he accomplished much more between sessions than did Maria, who was highly skeptical that therapy could help and was functioning at a lower level.

A reasonable Action Plan for one client may be unreasonable for another. Many clients, like Abe, are able to identify their automatic thoughts in the first session or two and you may suggest having them try to do the same between sessions. Maria, however, didn't grasp the cognitive model in the first session and, indeed, became slightly irritated when I tried to explain it to her in another way. She said, "You don't understand; I don't *know* what was going through my mind. All I know is that I was very upset!" An Action Plan to monitor her automatic thoughts would have been inappropriate at that session.

Provide or Elicit the Rationale

Clients are more likely to complete Action Plans when you provide a rationale, so they can see how and why it will help them. You might say, for example, "Research shows that exercise often helps people become less depressed. What do you think about getting more exercise a few times this week?"

Asking questions to link Action Plans to their aspirations, goals, and values can motivate clients. Here are some examples:

"Why go to the trouble of controlling your behavior when you're angry?"

"What would be the point of asking people if they know someone to fix you up with?"

"Why is it important to you to get a job?"

"Can you see how speaking up at work could help you feel more self-confident?"

"What would it say about you if you were able to help your neighbors?"

Set Action Plans Collaboratively

Take care not to unilaterally assign Action Plan items. Seek the client's input and agreement. For example, you might say,

"What would you think about [asking your boss to change your work schedule]?"

"Do you think it could help if [you read this coping card before you leave the house]?"

"Do you want to practice [a particular technique] this week?"

"I think if you [get in the shower as soon as you get up], you'll demonstrate to yourself that [you can take more control of your day]. What do you think? Is this something you want to try?"

Err on the Easy Side

A typical error made by novice therapists is suggesting Action Plans that are much too difficult for depressed clients, for instance, having them complete a daily thought record immediately after initiating the cognitive model. Remember, they usually lack energy and motivation. Their concentration and executive functioning skills may be impaired. When applicable, break a large task into more manageable parts. For example, you might suggest that clients read one chapter of a layman's CBT book, spend 10 minutes doing paperwork, or do one load of laundry.

Provide Explicit Instructions

Much of the time, you'll guide clients in deciding when, where, and for how long (and sometimes with whom) they should do Action Plan items. Abe and I agreed, for example, that he would go to the bank immediately

after one of our therapy sessions and ask for a loan application. He would then spend 15 minutes filling out the application as soon as he came home.

Set Up a Reminder System

It's vital to record, or have clients record, their Action Plans every week, starting with the first session. If the Action Plan is recorded in writing, ask clients where they'll keep it and how they'll remember to look at it. They can

- pair an Action Plan with another daily activity (e.g., "How about jotting down what you deserve credit for at mealtimes and right before bed?");
- post notes on their refrigerator, their bathroom mirror, their computer, or the dashboard of their car;
- use their appointment book, device, timer, or computer to cue them (you might suggest that they set an alarm on their cell phone as they're sitting in the office with you); and/or
- ask another person to remind them.

You can also ask them how they remember to do other regularly scheduled activities, such as taking vitamins or medication. For activities you want them to remember throughout the day (such as monitoring their automatic thoughts or giving themselves credit), they can post sticky notes or set alarms on their phones. Or you can suggest that they wear a rubber band on their wrist, switch their watch to the other wrist, or wear a bracelet they're unaccustomed to wearing. Each time they notice their wrist, they can remind themselves of the Action Plan.

Begin the Action Plan in Session

When applicable, suggest that clients begin Action Plans right in the therapy session itself. This gives you an opportunity to assess their capability. If you'd like clients to do worksheets, for example, make sure they can do them in session first; if they can't complete one with you, it is highly unlikely they'll be able to do it outside of session. Starting an Action Plan in session also makes it far more likely that clients will follow through at home. Continuing an Action Plan is much easier than initiating

one. This is especially critical because clients often describe the hardest part of doing Action Plans as the period *just before* they start.

Ask Clients to Imagine Completing an Action Plan Item

Clients are more likely to complete their Action Plans if they visualize a positive outcome. Suggest that they imagine a specific time in the coming week when they've just finished a task or activity. Ask them to imagine giving themselves credit. You can discuss various ways of doing this (e.g., "It's good I did that"; "I deserve credit [for doing that]"; "That's good"; "This is an important step for me"; "This is going to help me reach my goal").

It's also desirable for them to visualize and verbalize what was good about the experience, what the experience meant to them and what it said about them, and how they felt emotionally. See if they can experience some of the same positive emotion right there in the session with you (Beck et al., in press).

ANTICIPATING AND PREVENTING PROBLEMS

It's very important to predict the kinds of obstacles clients may face in completing Action Plans. To increase the probability of their doing so, there are several things you can do:

- Check on the likelihood of completion.
- Anticipate obstacles; do covert rehearsal when indicated.
- Be alert for clients' negative reactions.
- Examine advantages and disadvantages.
- Change the Action Plan.
- Make Action Plans a no-lose proposition initially.

Check on the Likelihood of Completion

It's important to predict potential obstacles when setting up Action Plans. Think about what automatic thoughts or practical problems might get in the way. The single most important question to ask clients to assess the probability that they'll complete their Action Plan is this:

> "How likely are you to do this, 0–100%?"

Identify Obstacles and Do Covert Rehearsal

When clients say they are less than 90% sure that they'll do their Action Plan, you'll need to find out what could get in the way. On one occasion, Maria was only 75% sure. I asked her:

> "What's the 25% part of you that thinks you won't do it?"

I could also ask:

> "Why are you 75% sure and not 50% sure?"
> "What could we do to get you from 75% to 95%?"
> "What are the advantages and disadvantages of doing the Action Plan?"

Depending on your client's answers, you can

- problem-solve,
- do skills training,
- help them respond to their interfering automatic thoughts, and/or
- make the Action Plan easier or optional.

I use several techniques with Maria to increase the likelihood that she will complete an Action Plan item. First, I ask about obstacles. Then I ask her to commit to when she would do it. Next, I use *covert rehearsal*. I ask her to visualize carrying out the Action Plan, and I help her respond to an

interfering thought. I ask her to imagine that she is reading the response. Finally, we talk about what she would like to remind herself to respond to another automatic thought.

JUDITH: Do you think anything will get in the way of your asking Randy for help?
MARIA: I'm not sure.
JUDITH: [getting her to specify and commit to a time] When would be a good time to call her?
MARIA: Saturday morning, I guess, because she won't be at work.
JUDITH: Can you imagine it's Saturday morning right now? Can you picture it? What time is it? Where are you?
MARIA: Around 10 o'clock, I guess. I'm in the kitchen. I've just finished breakfast.
JUDITH: Can you imagine saying to yourself, "I really should call Randy"?
MARIA: Yes.
JUDITH: How are you feeling?
MARIA: A little nervous, I guess.
JUDITH: What's going through your mind?
MARIA: I don't want to call her [automatic thought]. Maybe I'll just try to figure out how to organize my stuff myself.
JUDITH: Well, you *could* do that. Do you think you'd be successful?
MARIA: (*Thinks.*) No, I guess not. I've already tried, and I didn't know what to do. But she might say she's too busy or something [automatic thought in the form of a prediction].
JUDITH: She might. Do you want to remind yourself about what we just talked about? Calling her is an experiment. That we won't know what happens unless you call? That if she's not helpful, we'll figure out Plan B together? (*pause*) Would it help to put that on your Action Plan so you can read it a few times between now and Saturday morning?
MARIA: Probably.
JUDITH: Okay. Now can you imagine you're in the kitchen? You're thinking, "I'll just try to organize my stuff myself." Now what happens?
MARIA: I don't feel like calling her. I guess I should read the Action Plan.
JUDITH: Good idea. Where is it?
MARIA: In the top drawer of my dresser.

JUDITH: Can you see yourself getting it? Or would it be better to leave it in the kitchen?
MARIA: It's okay in my dresser. If anyone comes over, I don't want them to see it.
JUDITH: Okay. Can you imagine pulling out the Action Plan and reading it?
MARIA: Yeah.
JUDITH: Now, what happens?
MARIA: Probably I remember why I *should* call her, but I still don't want to. So I do something else instead.
JUDITH: What could you remind yourself at this point?
MARIA: That I may as well call her and get it over with. That maybe she *will* help. That if I don't call her then, I may end up not calling at all and miss out on potential help.
JUDITH: Good. Then what happens?
MARIA: I call her.
JUDITH: And then?
MARIA: Well, she'll either tell me she'll help or she'll say she can't.
JUDITH: And if she can't, we can figure out what to do next week. (*pause*) What do you think we should write on your Action Plan?

This kind of covert rehearsal using imagery helps you discover practical obstacles and dysfunctional cognitions that could hinder the completion of Action Plans.

Be Alert for Clients' Negative Reactions

When clients have a negative reaction as you're setting Action Plans, first positively reinforce them for letting you know. Then specify the problem and establish its meaning to the client. Next, intervene (or if there's insufficient time, mark the problem for intervention at the next session). In an early session, Maria and I have just finished discussing an Action Plan. I notice that she is looking more distressed.

JUDITH: Maria, are you feeling a little more upset now? What was just going through your mind?
MARIA: I don't know … I'm not sure this therapy is for me.
JUDITH: You don't think it'll help?

MARIA: No, not really. You see, I've got real-life problems. It's *not* just my thinking.

JUDITH: I'm glad you told me. This gives me the opportunity to say that I *do* believe that you have real-life problems. I didn't mean to imply that you don't. The problems with your mother and your sister and your feelings of loneliness … Of course, those are all real problems, problems we'll work together to solve. I *don't* think that all we need to do is look at your thoughts. I'm sorry if I gave you that impression.

MARIA: That's okay … It's just, like … well, I feel so overwhelmed. I don't know what to do.

JUDITH: Are you willing to come back next week so we can work on the overwhelmed feelings together?

MARIA: Yeah, I guess so.

JUDITH: Is the Action Plan contributing to the overwhelmed feeling too?

MARIA: (*pause*) Maybe.

JUDITH: How would you like to leave it? We could make the Action Plan optional, or some of it optional, if you want.

MARIA: (*sigh of relief*) Yeah, that would be better.

JUDITH: What seems hardest to do?

MARIA: Trying to keep track of my thoughts.

JUDITH: Okay, let's write "optional" next to that one. Or should I just cross it off?

MARIA: No, you can write "optional."

JUDITH: (*Does so*.) What else feels too hard?

MARIA: Maybe calling my friends. I don't know if I'm up for that.

JUDITH: Okay, should I write "optional" or cross it off?

MARIA: Maybe cross it off.

JUDITH: Okay. (*Does so*.) Now, is there anything else bothering you?

When Maria gives me negative feedback, I recognize that I need to strengthen the therapeutic alliance. What might have happened if I didn't ask for feedback or been less adept at dealing with her negative feedback? It's possible that Maria wouldn't complete the Action Plan. (It's also possible that she wouldn't return for another session.)

I use this difficulty as an opportunity to refine my conceptualization. My flexibility about the Action Plan helps Maria reexamine her misgivings about the appropriateness of CBT. By responding to feedback

and making reasonable adjustments, I demonstrate an understanding of and empathy for Maria, which facilitates collaboration and trust. In the future, I make sure she doesn't feel overwhelmed by Action Plans. And at the beginning of the next session, I reinforce the importance of our working as a team to tailor the treatment and the Action Plan so it's right for her.

Examine Advantages and Disadvantages

When clients are unsure they will follow through with an Action Plan item, you might collaboratively decide to look at the advantages and disadvantages of doing it versus the advantages and disadvantages of not doing it (see Chapter 19, pp. 327–329). Then you can ask clients to weigh the items to decide about what is most important to them. When eliciting advantages, find out whether clients predict they would feel relief by not doing the activity or task. If so, you may need to help them appreciate the larger picture.

JUDITH: What was your mood like when you decided to stay in bed until noon?
MARIA: (*Sighs.*) Well, first I felt better.
JUDITH: And how did you feel when you got up at noon?
MARIA: Pretty bad. I hadn't done all these things we had talked about doing.
JUDITH: So, what do you conclude?
MARIA: I always think I'm going to feel better when I stay in bed, but I usually don't, not for more than a few minutes anyway.
JUDITH: And does staying in bed get you closer to your long-term goals or further away?
MARIA: (*Sighs.*) Further away.

CLINICAL TIPS

Sometimes clients reveal ambivalence about the usefulness of an Action Plan. If so, you should acknowledge that you don't know what the outcome will be: "I don't know for sure that doing this *will* help." Then consider asking questions such as the following:

"What will you lose if it doesn't work?"
"What could be the potential gain in the long run if it does work?"

With some Action Plan items, you can say, "Haven't you already done the experiment of [*not* getting up and getting dressed before lunch]? How does that usually turn out? So would you like to try something different?"

Change the Action Plan

If you judge that an Action Plan item is inappropriate or if clients are still unsure they'll do it, you may need to modify it. It's far better to substitute an easier Action Plan item that clients are likely to do than to have them establish a habit of not doing what they had agreed to in session: "I'm not sure you're ready to do this. [or 'I'm not sure this Action Plan is appropriate'] What do you think? Do you want to go ahead and try or wait until another time?"

As illustrated earlier in this chapter, you can also collaboratively decide to make certain Action Plans optional or to decrease the difficulty, frequency, or duration of an Action Plan item.

Make the Action Plan a No-Lose Proposition (Initially)

When creating Action Plans in the first session or two, it's helpful to stress that useful data can be obtained even if clients fail to complete their Action Plans. Clients who don't do their Action Plans are then less likely to brand themselves as failures. You might say, "If you get this Action Plan done, that's good. But if you have trouble doing it, that's okay—just see if you can figure out what thoughts are getting in your way, and we'll talk about them next time. Okay?"

Sometimes clients fail to do a significant portion of their Action Plan for 2 weeks in a row, or they do it immediately before the therapy session instead of daily. In these cases, you should elicit the cognitions and/or practical obstacles that got in the way and stress how essential it is to do Action Plans daily, instead of continuing to make them a no-lose proposition.

PREPARING FOR A POSSIBLE NEGATIVE OUTCOME

There are times when you and the client just can't predict to what degree an Action Plan item will be successful. It's helpful to have therapy notes in the Action Plan for clients to read if it doesn't work out the way the client would have wanted. Abe, for example, fears that if he visits his mother, she'll be critical of him. But he decides to go anyway. We set the visit up as a behavioral experiment and jointly compose the following therapy note for him to read in case her attitude is negative.

If the visit to Mom doesn't go well, remind myself:

> "I didn't know whether Mom would be critical or not, but it was worth a try, and I deserve credit for visiting her. I don't need to take her criticisms to heart. She's critical toward everyone, not just me. And she didn't know about my depression, so her criticisms probably weren't justified. I wish she were different, but the reality is that she probably won't change. The next time I visit, I can tell her in advance that it will only be for a short while, and I can figure out some activity we can do together to try to get her focus on something else."

REVIEWING ACTION PLANS

Before each session, prepare by reviewing the notes and the Action Plan from the previous session. Review the Action Plan with the client toward the beginning of the session. Doing so gives clients the idea that Action Plans are important. Even if a client is in crisis, it's still useful to spend a few minutes discussing Action Plans later in the session or, in a different case, to collaboratively agree that the Action Plan from the previous session doesn't apply at the moment.

Deciding how much time to spend reviewing Action Plans and discussing whether clients want to continue any given Action Plan is part of the art of therapy. You will spend more time on Action Plans when

- they cover an important, ongoing issue or goal that requires further discussion;
- clients have not completed a task; and/or
- clients have difficulty drawing conclusions from successfully fulfilling their Action Plans or when they are critical of themselves for not doing a good enough job.

You will often ask clients to read their therapy notes aloud (or you can read them if they're reluctant). Then ask, "How much do you believe that?" If they don't endorse their therapy notes strongly, ask, "What part don't you believe?" or "What don't you agree with?"

When clients have successfully completed an activity or task on their Action Plan, there are several questions you can ask to help them derive positive meanings and strengthen positive beliefs about themselves (Beck et al., in press):

> "Were you able to give yourself credit for doing that?"
> "What was good about the experience [e.g., 'I helped other people'; 'My family is happy'; 'I got the job finished']?"
> "What emotions did you experience [e.g., 'I felt good'; 'I was pleased'; 'I felt proud']?" (You can give them a list of positive emotions (p. 229) to help them identify additional positive emotions they may have experienced.)
> "What did the experience mean to you [e.g., 'This shows _____'; 'It's worth putting in the effort'; 'People seem to like me']?"
> "What did the experience show about you [e.g., 'I can do hard things'; 'I can take control'; 'I'm stronger than I thought I was'; 'I'm a good person'; 'I'm likeable'; 'I'm effective/competent/capable'; 'I'm able to protect myself'; 'I'm able to make good decisions']?"

You can positively reinforce the client yourself, by saying something such as "It's great that you _____. This shows _____ [about you]."

When relevant, ask if clients want to continue this Action Plan item in the coming week.

CONCEPTUALIZING DIFFICULTIES

When clients have difficulty doing their Action Plan, conceptualize why the problem arose. Was the obstacle related to

- a practical problem?
- an interfering cognition?
- an interfering cognition masked as a practical problem?
- a problem related to your cognitions?

Practical Problems

Most practical problems can be avoided if you carefully and collaboratively create Action Plans and prepare clients to do them. Covert rehearsal can also help you identify potential obstacles. Most practical problems can be resolved through problem solving and/or skills training.

Three common practical problems that don't necessarily include unhelpful cognitions are

1. forgetting the rationale for an Action Plan,
2. disorganization or lack of accountability, and
3. difficulty with an item.

These obstacles are discussed below.

Forgetting the Rationale

Occasionally, clients neglect an Action Plan because they don't remember *why* it's important or how it's connected to their aspirations, values, or goals. This problem can be avoided by having clients (who have demonstrated this difficulty) record the rationale next to an Action Plan.

MARIA: I didn't do the Action Plan because I was feeling fine this week.
JUDITH: Do you remember what we said a few weeks ago—why it's helpful to practice the mindfulness exercise for 5 minutes every morning, regardless of how you're feeling?
MARIA: I'm not sure.
JUDITH: Well, let's say you don't practice the mindfulness exercise for a couple of weeks. Then you have a very stressful week and you find you're worrying a lot again. How sharp will your skills be then?
MARIA: Not very, I guess.
JUDITH: And how important does it feel to you to manage your stress so you can feel more relaxed around other people?
MARIA: It's still very important.
JUDITH: What do you think about practicing mindfulness this week, even if you're not stressed?
MARIA: I guess I should.

JUDITH: Maybe you can also write down why it's important to you to practice. What other reasons are there for reducing your stress? (*pause*) Any other problems that could get in the way?

If the rationale doesn't seem strong enough, you can see whether the client is willing to look at the advantages and disadvantages of doing the Action Plan versus the advantages and disadvantages of not doing it.

Disorganization or Lack of Accountability

Some clients are more likely to do their Action Plans when they have to mark off a daily checklist. You or clients can draw a simple diagram (Figure 8.1) in session, and they can fill it out each evening. This technique helps clients remember to do their Action Plans and also makes them aware of what they're *not* doing. Alternately, clients can write down their Action Plans on a daily calendar or appointment book or in their phone. (Do the first day together in the office, and ask clients to write down the rest after the session.) Later, after completing Action Plans, clients can put a checkmark next to them or cross them off.

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Read therapy notes.							
Make a credit list.							
Do a Thought Record when I'm upset.							
Organize bedroom for 10 minutes a day.							

FIGURE 8.1. Sample daily checklist for Maria.

CLINICAL TIPS

When clients' adherence is likely to be low, you can suggest they call your office to leave a message when they have completed an Action Plan item. Knowing that you expect a message may motivate clients to do it. As with any intervention, you should suggest these possibilities with a rationale and be sure that clients agree.

Difficulty with an Action Plan Item

If you realize at a subsequent session that an Action Plan item was too difficult or ill defined (common problems with novice therapists), take responsibility. Otherwise clients may unfairly criticize themselves. You might say:

> "Now that we've talked about it, I can see that I didn't explain the Action Plan well enough. [or 'I can see that it was really too hard.'] I'm sorry about that. What went through your mind when you couldn't [or didn't] do it?"

Here you have an opportunity to (1) model that you can make and admit to mistakes, (2) build rapport, (3) demonstrate that you are concerned with tailoring therapy—and Action Plans—to the client, and (4) help the client see an alternative explanation for his or her lack of success.

Interfering Cognitions

Whether clients have had a practical problem that posed an obstacle to completing their Action Plans, their difficulty may involve unhelpful cognitions. Some clients need to respond to maladaptive thoughts and beliefs before they're able to complete their Action Plans. They may believe:

"Having to do Action Plans means I'm defective."
"If I try to do the Action Plan, I'll just fail."
"I shouldn't have to put in so much effort to feel better."
"My therapist should cure me without my having to change."
"Action Plans are trivial and won't get me better."
"[My therapist] is trying to control me."
"If I think about my problems, I'll feel worse."
"If I do Action Plans and get better, my life will get worse."

Below are some strategies you can use for several types dysfunctional cognitions.

Negative Predictions

When clients are in psychological distress, and particularly when they're depressed, they tend to assume negative outcomes—as Abe does when considering whether to fill out an application for work. These predictions can interfere with starting or completing an Action Plan. When you find that clients haven't completed an Action Plan, ask them if they still think the Action Plan is a good idea and then have them predict obstacles to completing it in the coming week.

ABE: I didn't fill out the job application this week.
JUDITH: Do you still think it's a good idea?
ABE: (*Sighs.*) Yeah. I really need to get back to work.
JUDITH: What got in the way this past week? Was there a practical problem? Did you have enough time?
ABE: I had plenty of time. I'm not sure why I couldn't get myself to do it.

Then I did a form of covert rehearsal. Make sure you or the client records on the new Action Plan whichever statements seem helpful to the client.

JUDITH: Do you think you might have the same problem filling out the job application this coming week?
ABE: Yeah, probably.
JUDITH: Can you imagine doing it? How are you feeling?
ABE: Down, kind of tired.
JUDITH: What's going through your mind?
ABE: I might make mistakes on the application. Then they won't give me the job.
JUDITH: No wonder you were having trouble getting started. In fact, maybe we should have had you start filling it out right here in session. Can we look at this thought—that you might make mistakes? What do you want to be able to tell yourself this week if you have the same thought?

I then made suggestions to make his response more robust. Next, we agree that Abe will spend 10 minutes filling out the application as soon as he gets home from his therapy appointment. (He could spend longer on it if he wants to, but he doesn't have to.) And he will continue to work on it for

10 minutes a day until it's finished. Then we record the Action Plan, how he will accomplish it, and what he can say to himself if he has interfering thoughts.

Clients can often test negative predictions (such as "My roommate won't want to go to [that event] with me"; "I won't understand the instructions even if I ask for help"; or "Doing Action Plans will make me feel worse") through behavioral experiments. You can help clients evaluate other thoughts, such as "It's not worth the effort" or "Doing this will make no difference" with standard Socratic questioning.

Overestimating the Demands of an Action Plan

The negative predictions of some clients are overestimations of how inconvenient or difficult an Action Plan will be. Or they don't realize that doing an Action Plan will be time limited. It's a good idea to ask clients how long they think an Action Plan item will take.

JUDITH: What could get in the way of your doing a Thought Record a few times this week?
MARIA: I'm not sure I'll find the time. [automatic thought]
JUDITH: How long do you think they would take?
MARIA: I don't know. Half an hour? I'm pretty rushed these days, you know. I have a million things to do.
JUDITH: It's good you told me that. I actually want you to spend only 10 minutes doing a thought record. Does that sound easier?
MARIA: I'm not sure.
JUDITH: Maybe it's not worth it to you to find the time. Do you think in the long run it will improve your life, help you get a better life?
MARIA: (*Sighs.*) I guess so.

You can then do straightforward problem solving to find possible time slots. Alternatively, you might propose an analogy about prioritization and/or stress that the inconvenience of doing Action Plans is temporary:

JUDITH: It certainly is true; you *are* very busy these days. I wonder—this is an extreme example, I know—but what would you do if you had to take time every day to do something that would save your life [or your

loved one's life]? What would happen, for example, if you needed a blood transfusion every day?

MARIA: Well, of course I'd find the time.

JUDITH: Now, it's obviously not life threatening if you don't do Thought Records, but the principle is the same. In a minute, we can talk specifically about how you could cut back in another area, but first it's important to remember that this is *not* for the rest of your life. We just need you to rearrange some things for a little while until you're feeling better.

The client who overestimates the *energy* an Action Plan requires benefits from similar questions. In the next example, Maria has a dysfunctional (and distorted) image of fulfilling an Action Plan.

JUDITH: What got in the way of your going to the mall this week?

MARIA: (*Sighs.*) I just didn't have the energy.

JUDITH: What did you imagine would happen if you had gone?

MARIA: Well, I would have had to drag myself into one store after another.

JUDITH: You know, we talked about your going for just 15 minutes. How many stores would you actually get to in 15 minutes? I wonder if you were imagining that it would be more difficult than we had planned?

In a different situation, Maria has correctly recalled the Action Plan but again she has overestimated the energy it would require. I first help *specify the problem* by doing a modified, short version of covert rehearsal, and I ask her a question to link the Action Plan to one of her important values.

MARIA: I wasn't sure I'd have the energy to take Caleb to the park.

JUDITH: Was the problem mostly getting out of the house, going to the park, or what you'd have to do *at* the park?

MARIA: Getting out of the house. I have to get so much stuff together—his diaper bag, the stroller, a snack, his coat and boots …

JUDITH: Is going to the park connected to something important?

MARIA: (*Thinks.*) Yeah. I really do want to be a good aunt. It wasn't so good that I had him cooped up the whole day.

Next, we problem-solve; one solution is for Maria to gather all the necessities earlier in the day when she is feeling more energetic and less overwhelmed.

CLINICAL TIPS

Another problem can arise when clients try to do their Action Plans perfectly. They can benefit from a simple reminder, such as the following:

> "Learning to identify your automatic thoughts is a skill, like learning the computer. You'll get better with practice. So, if you have any trouble again this week, don't worry. We'll figure it out together at our next session."

Other clients with a strong underlying assumption about the necessity of being perfect may benefit from Action Plans that *include* mistakes:

THERAPIST: It sounds as if your idea about needing to be perfect is getting in the way of doing your Action Plan.
CLIENT: Yeah, I think it is.
THERAPIST: How about this week if we have you do a Thought Record that is *deliberately* imperfect? You could do it with messy handwriting or not do it thoroughly or make spelling mistakes. And how about if we put a 10-minute time limit on it?

Procrastination and Avoidance

Depressed clients often have difficulty getting started on their Action Plan. Earlier in this chapter, you read about several techniques you can use. It's often helpful to say:

> "Do you think you might focus on how you're feeling at the moment instead of how you'll feel when you finish it? Would it also help to remind yourself what goal you're trying to reach and why?"

Also, telling clients what *you* do when you find yourself procrastinating can help. For example, do you occasionally have difficulty initiating a task (e.g., getting yourself to work on a paper, pay taxes, or start exercising)? What do you do to get yourself going? Using self-disclosure can normalize the experience and provide an example of what they can do.

JUDITH: I'm sorry it's been difficult for you [to fill out the insurance forms]. Should I tell you how I get myself to do something I've been avoiding?

ABE: Yes.

JUDITH: When I'm avoiding something, I find the few minutes just before starting are the most unpleasant. Once I actually start doing it, I almost always feel better. This past weekend, I had to go through the mail on my desk. It was hard to get started, but I told myself I could stop after 10 minutes and that it was really likely it would get easier after a couple of minutes. And it did. (*pause*) Has that ever happened to you?

Abe recognizes that he often has the same experience. He commits to a behavioral experiment to see what will happen later in the afternoon when he sits down to fill out the forms.

Doing Action Plans at the Last Minute

Ideally, clients carry on the work of the therapy session *throughout the week*. For example, it's most useful for clients to catch and record their automatic thoughts at the moment they notice their mood changing or they're engaging in unhelpful behavior. Then they can respond to these thoughts either mentally or in writing. Some clients avoid thinking about therapy between sessions. Often this avoidance is part of a larger problem, and you may first have to help clients identify and modify certain beliefs (e.g., "If I focus on a problem instead of distracting myself, I'll only feel worse" or "I can't change, so why even try?"). Other clients, however, need only a gentle reminder to look at their Action Plan daily.

Interfering Cognitions Masked as Practical Problems

Some clients propose that practical problems such as lack of time, energy, or opportunity have prevented them from carrying out an Action Plan. If you believe that a thought or belief is also interfering, you should investigate this possibility *before* discussing the practical problem:

THERAPIST: Okay, you couldn't do the Action Plan because you didn't have time. Let's pretend for a moment that this problem magically

disappears. Let's say you have a whole day free. *Now* how likely are you do to the Action Plan? Would anything else interfere? Would any thoughts get in the way?

Problems Related to the *Therapist's* Cognitions

Finally, you should assess whether any of *your* thoughts or beliefs hinder you from being gently assertive about doing Action Plans. Typical dysfunctional assumptions of therapists include the following:

> "I'll hurt his feelings if I try to find out why he didn't do the Action Plan."
> "She'll get angry if I [nicely] question her."
> "He'll be insulted if I suggest he try an Action Plan monitor."
> "She doesn't really need to do Action Plans to get better."
> "He's too overburdened now with other things."
> "She's too passive–aggressive to do Action Plans."
> "He's too fragile to expose himself to an anxious situation."

Ask yourself what goes through *your* mind when you think about assigning Action Plans or exploring why a client has not done an Action Plan. If you're having dysfunctional thoughts, you might do Thought Records or behavioral experiments or consult a supervisor or peer. Remind yourself that you aren't doing clients a favor if you allow them to skip doing Action Plans (which research shows are important) and don't make a great enough effort to gain adherence.

SUMMARY

In summary, both you and your clients should view Action Plans as an essential part of treatment. Action Plans should be designed for the individual client and set collaboratively. Various techniques can be used to motivate clients to complete their Action Plans, including anticipating and preventing problems. When difficulties do arise, it's important to conceptualize the problem and plan a strategy to overcome it. Action Plans, properly assigned and completed, speed progress and allow clients to practice therapy techniques that they will need when treatment is over.

REFLECTION QUESTIONS

Think about an activity you have avoided. What practical problems or cognitions got in the way? What did you do or what could you have done to overcome your avoidance?

PRACTICE EXERCISE

Set a moderately difficult Action Plan item for yourself in the coming week that, if you complete it, will enrich your learning of CBT. Anticipate a problem that could arise, conceptualize the difficulty, and plan a strategy to overcome it.

9

TREATMENT PLANNING

It's helpful to view therapy as a journey, and the conceptualization as the road map. You discuss the client's aspirations and goals, the destination. There are a number of ways to reach that destination: for example, by main highways or back roads. Sometimes detours change the original plan. As you become more experienced and better at conceptualization, you fill in the relevant details in the map, and your efficiency and effectiveness will improve. At the beginning, however, it's reasonable to assume that you may not accomplish therapy in the most effective or efficient way. An accurate cognitive conceptualization helps you determine what the main highways are and how best to travel. In this chapter, you'll learn how to create a treatment plan for a client with depression. (You'll need to consult specialized texts for clients who have a different disorder or a comorbid condition.)

Here are the questions that are answered in this chapter:

- What are (and how do you accomplish) broad therapeutic objectives?
- How do you plan treatment across sessions?
- How do you create a treatment plan?
- How do you plan treatment to accomplish a specific goal?
- How do you plan individual sessions?
- How do you decide whether to focus on a particular goal or issue?
- How do you help clients who have difficulty identifying a problem?

ACCOMPLISHING THERAPEUTIC OBJECTIVES

Effective treatment planning requires a sound diagnosis, a solid formulation of the case, and consideration of clients' characteristics and their aspirations, values, sense of purpose, and goals. Treatment is tailored to the individual; you develop an overall strategy as well as a specific plan for each session. You also consider your conceptualization of the client; the stage of treatment; the client's values, state of mind, and level of motivation; and the nature and strength of the therapeutic alliance.

At the broadest level, your objectives are to facilitate a remission of clients' disorders; significantly improve their mood, functioning, and resilience; and prevent relapse. You arrange meaningful experiences for clients (in and out of sessions) that increase optimism, hope, and motivation along with their sense of control, worth, empowerment, purpose, connectedness, and well-being. You help them increase flexibility in how they think and act. My objectives with Abe, given his values and aspirations, are to help him see himself as a good family man and worker, someone who has grit and is resourceful, who can solve problems and overcome challenges, who helps other people, and who is confident that he has what it takes to lead a productive and satisfying life.

To achieve your therapeutic objectives, you will

- build a sound therapeutic alliance with clients;
- make the structure and the process of therapy explicit;
- monitor progress weekly and modify the treatment plan as needed;
- teach clients the cognitive model and share your conceptualization with them;
- alleviate their distress through a variety of interventions, including cognitive restructuring, problem solving, and skills training;
- increase positive affect by creating opportunities for meaningful, pleasurable, mastery-enhancing, and/or social experiences;
- develop and strengthen clients' adaptive (positive) beliefs about themselves, others, the world, and their future by helping them draw conclusions about their positive experiences, and identify and weaken their negative beliefs and draw more adaptive conclusions about their negative experiences; and
- teach clients how to use CBT and other techniques, generalize the use of the techniques, and motivate them to use the techniques in the future.

PLANNING TREATMENT ACROSS SESSIONS

Therapy can be viewed in three phases. In the beginning phase of treatment, you

- build a strong therapeutic alliance;
- identify and specify clients' aspirations, values, and their goals for therapy;
- identify steps to achieve each goal or solve each problem;
- resolve obstacles (automatic thoughts and problems) that interfere with taking steps toward goal attainment;
- socialize clients to the process of therapy (e.g., to collaboratively set agendas with you, provide feedback, and do Action Plans);
- educate clients about the cognitive model, their disorder, and various helpful coping strategies;
- emphasize clients' strengths, resources, and positive beliefs;
- teach clients to identify, evaluate, and respond to their automatic thoughts;
- help clients draw positive conclusions about their experiences, including what these experiences mean about them;
- teach clients needed skills; and
- help clients schedule activities (especially if they're depressed and avoidant).

It's especially important to facilitate a decrease in clients' symptoms and an improvement in their functioning *early in treatment*. Doing so is linked to decreased early termination and to better treatment outcomes (King & Boswell, 2019). It's also important to increase positive emotion throughout treatment (Dunn, 2012).

In the middle phase of therapy, you continue not only to work toward these objectives but also to emphasize strengthening clients' adaptive, more positive beliefs, and you more directly identify, evaluate, and modify clients' dysfunctional beliefs, using use both "intellectual" and "emotional" techniques. In the final phase of therapy, you add an emphasis on preparing for termination, continuing to work toward goals, increasing a sense of well-being, improving resilience, and preventing relapse. By this point, clients have become much more active in therapy, taking the lead in setting the agenda, identifying solutions to obstacles, responding to unhelpful thinking, taking therapy notes, and creating Action Plans.

CREATING A TREATMENT PLAN

You develop a treatment plan based on

- your diagnostic evaluation and the cognitive formulation of the disorder(s);
- the principles of treatment and general treatment strategies for that disorder;
- your conceptualization of the client;
- the client's aspirations, strengths, values, and sense of purpose; and
- the obstacles they face in taking steps to reach their goals.

You adapt your treatment plan to the individual, considering his or her characteristics and preferences, culture and age, religious or spiritual orientation, ethnicity, socioeconomic status, disability, gender, and sexual orientation. Having formulated a general treatment plan, you adhere to it to a greater or lesser degree, revising it as necessary. Analyzing obstacles to taking steps to reach their goals compels you to conceptualize clients' difficulties in detail and to formulate a treatment plan tailored to overcome them. Doing so also helps you focus each session, understand the flow of therapy from one session to the next, and become more aware of progress.

You'll find the initial treatment plan I devised for Abe in Figure 9.1.

OVERALL TREATMENT PLAN

- Reduce depression, hopelessness, and anxiety; increase optimism and hopefulness
- Improve functioning, social interactions, and self-care
- Increase positive affect
- Improve self-image and confidence
- Prevent relapse

VALUES, ASPIRATIONS, AND GOALS

- *Values:* Family, being a good person, responsible, useful
- *Aspirations:* To "get my old self back"; to be in control, productive, helpful to others, mentally healthy, a "good father and grandfather"
- *Goals:* Get a job, spend more time with children and grandchildren, reconnect with friends, get apartment in order, get along better with ex-wife (if possible), take better care of self (exercise, sleep, eating)

POTENTIAL OBSTACLES

- Pessimism, hopelessness, anxiety about future

- Low motivation, lack of energy, desire to avoid, inactivity
- Negative self-image, self-criticism, rumination
- Conflict with ex-wife

POTENTIAL INTERVENTIONS

- Provide psychoeducation about depression, anxiety, the cognitive model, and information processing, moving from the depressive to the adaptive mode, the importance of activity scheduling, the structure of sessions
- Increase positive emotions by creating positive experiences; schedule activities (self-care, interpersonal, home management, job seeking; mixture of mastery, pleasure, and interpersonal activities)
- Increase attention to and draw positive conclusions about these experiences
- Reconnect with family and friends
- Decrease time in bed and on the couch; decrease passive activities such as watching television, surfing the web
- Break down large tasks into smaller components
- Give self credit
- Examine advantages and disadvantages when making a decision (e.g., how to approach ex-wife, what kind of job to look for)
- Evaluate and respond to dysfunctional thoughts and beliefs, using guided discovery, Socratic questioning, and behavioral experiments
- Teach mindfulness skills to decrease rumination
- Do problem solving (especially of obstacles that could arise in coming week)
- Teach communication skills (e.g., role-play interactions with ex-wife and job interviewer)

FIGURE 9.1. Abe's initial treatment plan.

PLANNING TREATMENT TO ACCOMPLISH A SPECIFIC GOAL

It's helpful to identify the steps needed to help clients reach a goal or solve a specific problem. Figure 9.2 provides an example. You'll see it outlines the necessary steps and specifies obstacles for each step (practical problems, interfering cognitions, and/or skill deficits) and a plan to overcome them.

Goal: Getting a job

Identify steps and potential obstacles; create plan to address obstacles.

Step 1: Update résumé.

Potential Obstacles

- Automatic thoughts: “I won’t do this right”; “I won’t get hired anyway”
- Skill deficit: how to describe previous work experience

Plan to Overcome Obstacles

- Socratic questioning to evaluate automatic thoughts; summarize for therapy notes
- Look online for sample résumés
- Ask son for help; evaluate automatic thoughts that could pose obstacles (e.g., “I shouldn’t ask for help”); summarize for therapy notes
- Give self credit for taking these steps
- Set specific Action Plan to look online and ask son; assess likelihood of completion; if indicated, look for additional obstacles or change Action Plan

Step 2: Identify potential jobs and apply for them.

Potential Obstacles

- Automatic thoughts: “If I look online, I won’t be able to find any in my area”; “If I network, people will find out I’m unemployed and they’ll think less of me”
- Problem/skill deficit: doesn’t know where to look online

Plan to Overcome Obstacles

- Socratic questioning to evaluate automatic thoughts; summarize for therapy notes
- Ask son for help in finding job opportunities online

Step 3: Go on interviews.

Potential Obstacles

- Automatic thoughts: “I’ll make a bad impression”; “I’ll mess it up”

Plan to Overcome Obstacles

- Role-play
- Work on making good eye contact; firm handshake, smiling, acting as if he’s confident

FIGURE 9.2. Sample plan for a specific goal.

PLANNING INDIVIDUAL SESSIONS

When planning a session, remember that the way people get better is by making small changes in their thinking and behavior every day. Before and during a session, ask yourself questions to formulate an overall plan for the session and to guide you as you conduct the therapy session. At the most general level, ask yourself:

> "What am I trying to accomplish, and how can I do so most efficiently?"

Experienced therapists automatically reflect on many specific issues. If you're a novice therapist, the following list may look daunting. But it's useful to read it now and review it periodically, especially just before sessions. It will help you make better decisions about how to proceed within the session. Consciously contemplating the questions *during* a session would undoubtedly interfere with the therapeutic process.

1. As you review your notes from the previous session *before the session*, ask yourself:

   "What, if anything, do I need to do today to strengthen our alliance?"

   "What is the cognitive formulation [most important cognitions, coping strategies, and maintaining factors] for the client's disorder? What is my conceptualization of the client?"

   "Do I need to vary treatment to accommodate the client's individual characteristics?"

   "What has happened in the past few therapy sessions? What progress have we made toward the client's goals and helping the client achieve a better level of functioning and sense of well-being? What obstacles have been interfering?"

   "How can I build on the client's strengths, assets, and resources, and how can I help the client experience positive affect in the session?"

   "At which stage of therapy are we [beginning, middle, or final], and how many sessions do we have left [if there is a limit]?"

   "At which *cognitive* level have we primarily been working: automatic thoughts, intermediate beliefs, core beliefs, or a mixture? What

behavioral changes have we been working toward? Which skills do I need to reinforce or introduce?"

"What was the client's Action Plan? What, if anything, did I agree to do [e.g., call client's health care provider or find relevant bibliotherapy]?"

2. As you begin the therapy session and check on the client's *mood*, ask yourself:

"How has the client been feeling since our last session compared to earlier in treatment? Which moods predominate?"

"Do objective scores match the client's subjective description? If not, why not?"

"Is there anything about the client's mood we should put on the agenda to discuss more fully?"

3. As the client provides a *brief review of the week*, ask yourself:

"How did this week go compared to previous weeks? When was the client at his best in general?"

"What signs of progress are there? What positive experiences did the client have? What conclusions did the client draw about these experiences and about herself?"

"Did anything happen this week [positive or negative] that we should put on the agenda to discuss more fully?"

4. As you check on the client's *use of alcohol, drugs, and medication* (if applicable), ask yourself:

"Is there a problem in any of these areas? If so, should we put it on the agenda to discuss more fully? And/or does the client have a goal in any of these areas?"

5. As you and the client *set the agenda*, ask yourself:

"Which goal(s) does the client want to work toward this week? Or what problem(s) does the client want my help in solving?"

6. As you and the client *prioritize agenda items*, ask yourself:

"Which agenda item is most important to discuss first?"

"How much time will each agenda item take? How many items can we discuss?"

"Are there any goals or issues the client could resolve alone or with someone else, or bring up at another session?"

7. As you and the client *review the Action Plan*, ask yourself:

"When was the client at his best in relation to his goal(s) in the past week?"

"How much of the Action Plan did the client do? What obstacles or challenges, if any, got in the way?"

"Was the Action Plan useful? If not, why not?"

"What did the client learn from the Action Plan? What did the client conclude about her experiences and about herself?"

"How much does the client agree with the therapy notes from last week [and previous weeks, if still relevant]?"

"Which Action Plan items [if any] would be beneficial for the client to continue in the coming week?"

"How, if at all, should we modify the Action Plan we create today to make it more effective?"

8. As you and the client discuss the *first agenda item*, ask yourself questions in four areas:

Defining the Issue or Goal

"What is the specific issue or goal the client wants to work on?"

"How does this issue or goal fit into my overall conceptualization of the client?"

Devising a Strategy

"What has the client already done to try to resolve the issue or reach the goal?"

"What would *I* do if *I* were in the client's position and had this issue or goal?"

"Do we need to do problem solving? What cognitions might interfere with problem solving, carrying out a solution, or making progress toward the goal?"

Choosing Techniques

"What specifically am I trying to accomplish as we discuss this agenda item?"

"Which techniques have worked well for this client [or for similar clients] in the past? Which techniques have *not* worked well?"

"Which technique should I try first?"

"How will I evaluate its effectiveness?"

"Will I employ the technique or employ it *and* teach it to the client?"

Monitoring the Process

"To what degree are we working together as a team?"

"Is the client having interfering automatic thoughts about himself, this intervention, our therapy, me, the future?"

"Is the client's mood improving? How well is this technique working? Should I try something else?"

"Will we finish discussion of this agenda item in time? If not, should I suggest continuing this item and curtailing or eliminating discussion of another item?"

"What Action Plan might be beneficial?"

"What should we record for the client to review at home?"

9. *Following discussion of the first agenda item*, ask yourself:

"How is the client feeling now?"

"Do I need to do anything to reestablish rapport?"

"How much time is left in the session? Do we have time for another agenda item? What should we do next?"

10. *Before closing the session*, ask yourself:

"Did we make progress? Is the client feeling better?"

"Is the client committed and highly likely to do the Action Plan we agreed on?"

"In addition to asking for feedback, do I need to probe for any negative reactions [that the client hasn't expressed]? If there is negative feedback, how should I address it?"

11. *After the session*, you ask yourself:

"How should I refine my conceptualization?"

"Do I need to improve our relationship?"

"How would I score myself on each item of the Cognitive Therapy Rating Scale [*beckinstitute.org/CBTresources*]? If I could do the session over again, what would I do differently?"

"What do I want to remember to address in the next session? Future sessions?" [You can write these things down on your previous or next Session Note or put a sticky note in the client's chart.]

DECIDING WHETHER TO FOCUS ON AN ISSUE OR GOAL

A critical decision in every therapy session is deciding how to spend the time. Although you collaborate in making this decision with clients, ask yourself:

> "Which issue(s) or goals can we work on that will help the client feel better by the end of the session *and* have a better week?"

You gently guide clients away from discussion of issues that

> - they can resolve themselves,
> - are isolated incidents unlikely to recur,
> - are not particularly distressing or associated with dysfunctional behavior, and/or

- they are unlikely to make much progress toward while more pressing issues need to be addressed.

You also avoid problems or goals that clients don't want to work on, unless you conceptualize that it's very important to do so at that session. Even then, you initially try to conceptualize why the client doesn't want to discuss them. Responding to what they see as the disadvantages may increase their willingness. Even if they're not willing to discuss them in full, they may be willing to spend just a few minutes on them. Ultimately, though, you need to respect their decision.

JUDITH: Maria, do you think we should talk about the upcoming holiday with your family.
MARIA: No, not really.
JUDITH: I'm concerned that you could have a repeat of what happened last month. Would it be okay if we just looked at the disadvantages of discussing it? And then maybe we can look at the potential advantages.

Having identified and specified an issue or goal, you need to decide (collaboratively with the client) how much time and effort to spend on it. You should gather more data (if needed), review your options, reflect on practical considerations, and use the stage of therapy as a guide.

When clients first bring up an issue, either while setting the agenda or later in the session, you assess the nature of the problem and turn it into a goal. For example, Abe has put a new problem on the agenda: His cousin's business is failing, and Abe feels badly for her. I ask Abe what his goal is in relation to this problem so we can assess how useful it will be to devote a significant portion of therapy time to it.

JUDITH: Okay, you said you wanted to bring up something about your cousin?
ABE: Yeah. Her business has been pretty rocky for a while, but now it looks as if it may go bankrupt. I'm really sad for her.
JUDITH: What would be your goal in talking about this? Do you want to help her in some way?
ABE: No, I don't think there's anything I can do.

JUDITH: How sad do you feel? Do you think you're feeling "normal" sadness over this? Or do you think this is affecting you *too* strongly?
ABE: I think I'm having a normal reaction.
JUDITH: [having assessed no further work on this problem is warranted] Anything else on this?
ABE: No, I don't think so.
JUDITH: Okay. I'm sorry this happened to your cousin. (*pause*) Should we turn to the next item on our agenda?

Abe doesn't seem to be having distorted thoughts about this issue, he's not catastrophizing; the issue seems to be time limited, and most importantly, he's having a normal emotional reaction to it. So we collaboratively decide to start talking about another agenda item, Abe's goal to look for a new apartment, which *does* warrant intervention.

JUDITH: You wanted to talk about maybe getting a new apartment?
ABE: Yes. But just thinking about it makes me really nervous. I don't know where to start.

Unlike the issue with his cousin, it was clear that investigating the possibility of moving was a reasonable goal and that we had enough time in the session to discuss what could get in the way and still have time for other important issues or goals. I help Abe figure out what an initial step could be. We look for obstacles that could get in the way, and I do some combination of helping Abe respond to cognitions that could derail him, solving problems, and teaching necessary skills.

HELPING CLIENTS IDENTIFY A PROBLEMATIC SITUATION

Sometimes clients recognize they are distressed but can't identify a particular *situation* or issue that is associated with their distress (or which part of a situation is the most upsetting). When this happens, you can help them pinpoint the most problematic situation by proposing several potentially upsetting problems, asking them to hypothetically fix one

problem, and determining how much relief the client feels. Once a specific situation has been identified, the automatic thoughts are more easily uncovered.

JUDITH: [summarizing] So, it sounds as if you've been very upset for the past few days and you're not sure why, and you're having trouble identifying your thoughts—you just feel upset most of the time. Is that right?
MARIA: Yes. I just don't know why I feel so bad.
JUDITH: What kinds of things have you been thinking about?
MARIA: Well, I'm still fighting with my mom. And my sister is mad at me too. I still can't find a job, my apartment is a mess, and, I don't know, everything.
JUDITH: Anything else?
MARIA: I haven't been feeling too well. I'm afraid I might be getting sick.
JUDITH: Which of these situations bother you the most? Your mom, your sister, not having a job, your apartment, or feeling sick?
MARIA: Oh, I don't know. They're all pretty bad.
JUDITH: Let's say hypothetically we could completely eliminate the feeling sick problem. Let's say you now feel physically fine, how upset are you now?
MARIA: About the same.
JUDITH: Okay. Say, hypothetically, your mom and your sister call and apologize and say they want to have a better relationship with you. How do you feel now?
MARIA: Somewhat better.
JUDITH: Okay. Let's say you find out you got the job you interviewed for after all. Now how do you feel?
MARIA: Much better. That would be a great relief.
JUDITH: So it sounds as if it's the job that's the most distressing situation.
MARIA: Yeah. I think so.
JUDITH: In a moment, we'll talk more about getting a job, but first I'd like to go over how we figured it out, so you can do it yourself in the future.
MARIA: Well, you had me list all the things I was worried about and pretend to solve them one by one.

JUDITH: And then you were able to see which one would give you the most relief if it had been resolved.
MARIA: Yeah.

The same process can be used to help the client determine which *part* of a seemingly overwhelming problem is most distressing.

CLINICAL TIPS

Sometimes you can't easily assess how difficult a goal will be to reach or how likely it is that a particular discussion will trigger a painful core belief. In these cases, you may *initially* focus on a goal but collaboratively decide to switch to another goal when you realize your interventions aren't successful and/or the client is experiencing greater (unintended) distress, as you'll see in the following interchange I had in an early therapy session with Maria.

JUDITH: Okay, next on the agenda. You said you'd like to meet more people. (*We discuss this goal more specifically*.) Now, how could you meet new people this week?
MARIA: (*in a meek voice*) I could talk to people in my building, I guess.
JUDITH: (*noticing that Maria suddenly looks downcast*) What's going through your mind right now?
MARIA: It's hopeless. I'll never be able to do it. I've tried this before. (*Appears angry*.) All my other therapists have tried this too. But I'm telling you, I just can't do it! It won't work!

I hypothesize from Maria's sudden negative affect shift that a core belief has been activated. I recognize that continuing in the same vein at this time will likely be counterproductive. Instead of refocusing on the goal, I decide to repair the therapeutic alliance by positively reinforcing her feedback ("It's good you told me that"). Then I give her a choice about whether to return to this agenda item ("Would you like to talk some more about meeting new people, or should we come back to it another time [at another session] and move on to the issue that you're having with your mom?").

SUMMARY

The overarching goals of treatment are to facilitate remission of clients' disorders; to increase their sense of purpose, meaning, connectedness, and well-being and to build resiliency and prevent relapse. To achieve these objectives, you need to have a solid understanding of clients' current symptoms and functioning; aspirations, goals, and values; and presenting problems, precipitating events, history, and diagnosis. The treatment plan should be based on your ongoing conceptualization, and you should share

your treatment plan with clients and elicit feedback. It's important to plan treatment both for individual sessions and across the course of treatment.

REFLECTION QUESTIONS

What is an example of a problem or goal that would be helpful to work on in a therapy session with a client? Why would it be helpful? What is an example of a problem or goal that wouldn't be helpful to work on? Why wouldn't it be helpful?

PRACTICE EXERCISE

Let's say your goal is to become more proficient in CBT in the next year. Create a plan to reach this goal. Use Figure 9.2 as a guide.

10

STRUCTURING SESSIONS

Because you have so much to cover in Session 1, it has a different format from the rest of the sessions. We find the format described in this chapter to be the most efficient and effective way to conduct treatment. Having said that, it's important to deviate from the structure if you find the client is uncomfortable with it. In this chapter, you'll read excerpts from Abe's fifth session, and you'll find the answers to these questions:

How do you determine the content of sessions?
What happens in each part of a therapy session (mood/medication/other treatments check, setting initial agenda, obtaining an update and reviewing the Action Plan, discussing agenda items, periodic summaries, summary of session, final review of new Action Plan, and feedback)?

You'll see these session elements in the video of Session 10 with Abe (*beckinstitute.org/CBTresources*). You'll learn about typical problems that arise in structuring sessions in Chapter 11.

CONTENT OF SESSIONS

The content of sessions varies according to the client's issues and goals and your therapeutic objectives. When planning an individual session, you're mindful of the stage of therapy and you continue to use your conceptualization of the client to guide treatment. As clients report on

their mood, briefly review the week, and specify agenda topics, think about how to integrate your therapeutic objectives with your client's agenda items.

For example, in Session 5, my plan was to continue teaching Abe (though not necessarily all depressed clients) to evaluate his automatic thoughts and to continue to schedule activities. We also addressed the goals he put on the agenda. If you're new to CBT, you may have time to discuss only one or two issues or goals in depth during a session. Experienced therapists can often cover more.

See Figure 10.1 for Session Notes from my fifth treatment session with Abe. It's important to take notes during the therapy session

- to keep track of what is being covered,
- to refine your conceptualization, and
- to plan future sessions.

Preparatory Notes: *Continue activity scheduling and evaluating automatic thoughts; check on credit list.*

PATIENT'S NAME: *Abe K.* **DATE:** *6/10*

SESSION# *5* **DIAG./CPT CODE:** *F 32.3*

MOOD RATING/OBJECTIVE MEASURES (SPECIFY): *Feeling "a little better." PHQ-9 = 15; GAD-9 = 6; Well-being = 3.*

MEDS/changes/side effects/other treatment: *None.*

RISK ASSESSMENT—suicidal/self-harm/homicidal ideation: *No longer has thoughts of death; low risk.*

UPDATE/ACTION PLAN REVIEW/CONCLUSIONS DRAWN: *Got more done in apartment/changing thinking and behavior affects mood/shows taking more control; out of apartment every day/sees he's starting to take a "little more control"; felt best at concert/shows he values family/worth it to push self; read therapy notes daily; got out daily; babysat for granddaughters; dinner with son and family/good to get out/good to be with them/deserves credit; identified ATs; gave self credit.*

AGENDA ITEMS: *"Hard stuff" in apartment, ~~volunteering/tiredness~~, working for Charlie, evaluate automatic thoughts, schedule activities.*

AGENDA ITEM 1—PROBLEM OR GOAL: *Working for Charlie*

CONCEPTUALIZATION—automatic thoughts/(meaning/beliefs, if identified)/emotions/behaviors: *Situation: Thinking about working a full day → AT: "I don't have the stamina." → Emotion: "Worried" → Behavior: Avoided calling Charlie back.*

INTERVENTIONS OR THERAPIST SUMMARY: *(1) Taught the "What makes me think …?" question to evaluate "I don't have the stamina …"; (2) Significant evidence AT is true; (3) Evaluated options when talking to Charlie; (4) Role-played what to say to Charlie.*

ACTION PLAN: *Ask Charlie to keep him in mind for future work. Remind self that stamina will improve as depression improves.*

AGENDA ITEM 2—PROBLEM OR GOAL: *Sorting mail, paying bills, filling out forms*

CONCEPTUALIZATION—automatic thoughts/(meaning/beliefs, if identified)/emotions/behaviors: *Situation: Thinking about getting started → AT: "It's too hard." → Emotion: "Depressed" → Behavior: Avoided mail.*

INTERVENTIONS: *(1) Skills training (divide mail in four categories); (2) Evaluated AT (Response: "I don't have to do everything. The first step is just sorting. I should be able to do the sorting. If unsure, immediately put items in 'unsure' pile and discuss next session.") Also discussed what to do with the piles next session; (3) Covert rehearsal; (4) Imagine completing task; (5) Response to AT ("I should have done it sooner"): "The depression got in the way"; (6) Set alarm on phone for tomorrow morning.*

ACTION PLAN: *Read relevant therapy notes, imagine completing task, sort mail for tomorrow morning.*

OTHER ACTION PLAN ITEMS: *Keep credit list; get out of apartment every day; see family, take grandsons to baseball game; identify automatic thoughts and ask, "What makes me think this thought is true? What makes me think it's untrue, or not completely true?"*

SUMMARY/CLIENT FEEDBACK: *Feeling better linked to changed thinking, behavior, and giving self credit; importance of taking control; very likely to complete Action Plan. Feedback—"good."*

THERAPIST'S SIGNATURE: *Judith S. Beck, PhD*

NOTES FOR NEXT SESSION: *Discuss volunteering? Increasing stamina? Assess self-criticism; continue activity scheduling and teaching evaluation of automatic thoughts.*

FIGURE 10.1. Session Notes. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

As you take notes, maintain eye contact as much as possible. It's important at times, especially when clients are revealing emotionally painful material, *not* to take notes so you can be more fully present with the client.

Format of a Typical Session

Figure 10.2 lists the parts of sessions. It's helpful to provide rationales for each part in the first couple of therapy sessions. It's also important to make periodic summaries throughout each session. In the initial stage of treatment, you'll continue to socialize clients to CBT: following the session format, working collaboratively, providing feedback, and starting to view ongoing (and often past) experience in light of the cognitive model. If clients are feeling somewhat better, you'll also start relapse prevention (Chapter 21). Above all, you're concerned with inspiring hope, strengthening or maintaining the therapeutic alliance, and helping clients feel better and become more functional.

Initial Part of Session

1. Conduct a mood/medication/other treatment check.
2. Set the agenda.
3. Ask for an update (positives and negatives), and review Action Plan from the previous week.
4. Prioritize the agenda.

Middle Part of Session

5. Work on agenda item 1, summarize, make intervention(s), assess need for further interventions, and discuss Action Plan items.
6. Work on agenda items 2 and 3 (if time).

End of Session

7. Summarize the session.
8. Review the Action Plan for the coming week.
9. Elicit feedback.

FIGURE 10.2. Structure of sessions.

THE FIRST PART OF THE SESSION

The specific objectives of the introductory part of the session, described below, are to

- reestablish rapport,
- collect data to find out what issues/goals will be important to cover in the session, and
- draw conclusions about what the client accomplished as a follow-up to the previous session.

To accomplish these objectives, you will (1) do a mood/medication check, (2) set an initial agenda, (3) ask for an update and review the Action Plan, and (4) prioritize the agenda. Experienced CBT therapists tend to interweave these four elements, but I've separated them in this chapter for clarity. You may find that the beginning of each session proceeds more quickly if you ask clients to review (mentally or in writing) the Preparing for Therapy Worksheet (Figure 10.3) prior to the session. You can keep these worksheets in the reception area or you can send them home with clients until they're socialized to give you a concise report of the previous week without this prompt.

1. What did we talk about last session that was important? How much do I believe my therapy notes?
2. What has my mood been like, compared to other weeks?
3. What positive experiences did I have this week? What did I learn? What do these experiences say about me?
4. What else happened this week that's important for my therapist to know?
5. What are my goals for this session? Think of a brief title for each (e.g., connecting more with people, getting more done around the house, and concentrating better at work).
6. What did I do for my Action Plan? (If I didn't do an item, what got in the way?) What did I learn?

FIGURE 10.3. Preparing for Therapy Worksheet. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

Mood Check

The brief mood check creates several opportunities:

- You demonstrate your concern for how clients have been feeling in the past week.
- You and they can monitor how they've been progressing over the course of treatment.
- You can identify (and then reinforce or modify) their explanation for progress or lack thereof.
- You can reinforce the cognitive model: that their thoughts and activities have influenced their mood.
- You can check on suicidal ideation, hopelessness, or aggressive or homicidal impulses that will need to be addressed in the session, usually as the first agenda item.

According to clients' diagnoses and symptomatology, you might also ask for additional information, for example, the number and severity of panic attacks, time spent doing rituals, binges, substance use, angry outbursts, self-harm, or aggressive or destructive behavior. Here's how my fifth session with Abe begins.

JUDITH: Hi, Abe. How are you?
ABE: Okay (*handing over the scales he filled out*).
JUDITH: Are you feeling about the same? Better? Worse?
ABE: A little better. Well, there was one time this week when I felt much worse, but for the most part, it was better.
JUDITH: When we set the agenda, I'd like you to tell me about that time. But I'm really glad you had another better week. (*pause*) What was your sense of well-being like?
ABE: About a 3.
JUDITH: It seems your mood has been improving, little by little. (*pause*) Does it seem that way to you, too?
ABE: Yeah, I think so.
JUDITH: (*looking at his scales*) It looks like you're having a little more energy? And you're enjoying things just a little more?
ABE: Yeah, that's right.

It's important to get clients' attribution for an improved mood. We want to help them see that positive changes in their thinking and behavior are associated with feeling better.

JUDITH: That's good. Why do you think your mood improved this week?
ABE: I guess I've been feeling a little more hopeful, like maybe therapy is helping.
JUDITH: [subtly reinforcing the cognitive model] So you thought, "Maybe therapy is helping," and that thought made you feel slightly more hopeful, less depressed?
ABE: Yes … and I got a fair amount done in my apartment this week. And spent time with my kids.
JUDITH: Okay, so changing your thinking and changing your behavior is really affecting your mood.
ABE: Yeah, I think so.
JUDITH: Do you want to continue doing those things this week?
ABE: I do.

Next, I help Abe draw some positive conclusions about his behavior.

JUDITH: What does it *mean* that you were able to do these things? You weren't able to a few weeks ago.
ABE: I guess that I'm taking more control.
JUDITH: [providing positive reinforcement] Absolutely.

CLINICAL TIPS

- Sometimes clients are unsure as to why they're feeling better. If so, ask, "Have you noticed any changes in your thinking or in what you've been doing?"
- If there's a discrepancy between clients' narrative description of their mood from the past week and the scales they filled out, you might say, "So you've been feeling worse, but the score on this depression questionnaire is actually lower than last week. What do you make of that?"

Three common difficulties can arise during the mood check (you'll read about them in the next chapter): when clients attribute positive changes in their mood to external factors, when clients give too detailed a description of their mood, and when clients have experienced a worsening in mood.

Medication/Other Treatments Check

We covered the medication check previously (pp. 90–91). As a reminder, when relevant, you'll ask about clients' adherence to their prescribed medication (and difficulty with side effects) and other treatments. And when relevant, you'll help clients create a list of questions for their prescriber.

Setting an Initial Agenda

The purpose of this relatively *brief* segment is to set an initial agenda. Here's what to do:

- Ask clients for their goal(s) for the session and find out (either next or when you prioritize the agenda) if there's anything even more important to discuss. (*Note:* In traditional CBT, we'd be more apt to start by asking, "What problems do you want my help in solving?" or "What do you want to work on today?")
- Gently interrupt clients when needed to *label* the goal or issue, instead of describing it at length.
- Check your notes from the previous session and inquire about items you didn't have time to cover.
- Propose topics *you'd* like to cover.

Throughout the first part of the session, you should also

- ask whether clients anticipate any other important issues in the coming week, and
- be alert for other important agenda items, such as negative experiences from the past week that are likely to recur in the coming week.

Toward the end of the initial part of the session, you'll also help the client prioritize topics to cover in the rest of the session.

JUDITH: Let's set the agenda, if that's okay, so we can figure out what's most important to you to talk about. What's your goal for today's session?

ABE: Well, I've made some headway in my apartment, but there's still a lot to do to clean it up. Some of the stuff is really hard and …

JUDITH: (*gently interrupting*) Okay (*writing down the goal*), "Cleaning hard stuff in the apartment." Anything else?
ABE: I'm wondering if I'm in good enough shape to go volunteer again … I don't know; I'm pretty tired [potential obstacle] and …
JUDITH: (*gently interrupting*) Would you like to discuss that, too? (*pause*)
ABE: Yeah, if we have time.
JUDITH: Okay, "Volunteering and tiredness." Anything else?
ABE: Nothing I can think of right now.

Rather than having Abe provide a full description of these topics, I lightly interrupt and name the goal/issue. Had I allowed him to provide a lengthy description of these issues, *I would have deprived him of the opportunity to reflect on what he* most *wanted to talk about during the session*—which may or may not have been the first issue he brought up. I also probe for additional agenda topics.

JUDITH: You mentioned that you felt much worse one time this week. Is that something we should talk about?
ABE: I'm not sure. I got this bad phone call from my ex-wife. She was yelling at me for still being out of work so I can't pay her any more alimony. I felt really bad for a while. But that was the day I took my granddaughters to a concert, and by the time I got back, I felt better.
JUDITH: Should we put your ex-wife on the agenda?
ABE: Yeah, at some point, but not today, I don't think. She probably won't call me again for another couple of months.
JUDITH: Okay, is there anything coming up this week that I should know?
ABE: (*Thinks.*) Oh, yeah. My friend, Charlie, said he had some construction work for me. But I don't know if I'm up for it.
JUDITH: Should we look at the advantages and disadvantages of doing work for him?
ABE: Yeah, that would be good.

For clients who have difficulty figuring out what they want to put on the agenda, see pages 200–203. Next, I propose my agenda topics.

JUDITH: And along the way, I'd like to tell you some more about evaluating your thoughts and scheduling activities again—if that's okay.
ABE: Okay.

Update and Action Plan Review

Next, you draw a bridge between the previous session and the current one. Often, you'll combine a review of the Action Plan with the update. You'll continue to remain alert for issues or goals that could be important for the agenda. Traditionally, we started the update by asking clients, "What happened in the past week that's important for me to know?" When you ask that question, particularly toward the beginning of treatment, you'll find that clients usually report negative experiences. If so, it's important to ask them about positive experiences or times when they felt even a little better. In a recovery orientation, we tend to start with the positive by asking a question (or questions) such as:

> "What happened this week that was good?"
> "What did you do this week that was good?"
> "When were you at your best this week?"
> "What was the best part of the week?"

Emphasizing the positive helps clients see reality more clearly, as the depression has undoubtedly led them to focus almost exclusively on the negative. It helps them recognize that they didn't feel the same unrelenting severity of distress for the entire week. Naming positive experiences also gives you the opportunity

- to praise clients for engaging in meaningful social, productive, pleasurable, or self-care activities;
- to help clients draw helpful conclusions about the activities, including the positive things they indicate about the client;
- to evoke positive emotion in the session, putting clients in a better frame of mind and making them more receptive in the remainder of the session;
- to discuss whether the client thinks it's a good idea to engage in similar activities in the coming week; and
- to strengthen the therapeutic relationship by becoming briefly conversational, perhaps using some self-disclosure.

JUDITH: When were you at your best this week?

ABE: (*Thinks.*) When I saw my granddaughters. I took them to a kids' concert. They really like this singer—I forget his name; he plays the guitar and sings kids' songs.

JUDITH: [using self-disclosure to strengthen the therapeutic bond] I remember taking my own kids to events like that. I really should look into taking my grandchildren to a concert.

ABE: I think this guy has another concert this coming weekend.

JUDITH: Oh, thanks. (*pause*) Was taking your grandchildren out unusual for you?

ABE: Yeah, I used to do it, but I haven't done something like that for a long time.

JUDITH: [eliciting positive conclusions] What was good about the experience?

ABE: They were just really excited. And they were really happy I took them.

JUDITH: Well, I'm glad you were able to do that. (*pause*) What did you learn?

ABE: I guess that it was worth it to push myself. I was really tired and I didn't feel like going, but I didn't want to let them down. I should be doing things like this more often.

JUDITH: That's good. [trying to elicit an adaptive core belief] And what does it say about *you* that even though you're so depressed and tired, you were able to get yourself to go?

ABE: I'm not sure.

JUDITH: Does it show that you really value your family, that you were willing to push yourself, that maybe you can take more control of your mood than you thought?

ABE: I guess that's right.

JUDITH: Were there any other good things that happened this week?

ABE: That was the best thing. I also got a lot done on my Action Plan.

JUDITH: Good. We'll get to that in a minute.

Take note of the positive data. You may use this information later in the session or in future sessions, especially when planning positive activities for clients to engage in or when helping them evaluate relevant automatic thoughts and beliefs. Next, ask about other parts of the client's week.

JUDITH: Did anything else happen this week that's important for me to know?
ABE: (*Thinks*.) Umm. (*Sighs*.) Yeah, I think my younger brother is annoyed with me because I told him I didn't think it was a good idea for him to leave his job.
JUDITH: [probing to see whether it is important enough to add to the agenda] Is that something we should talk about today?
ABE: No, I don't think so. It'll blow over.
JUDITH: Okay, anything else?
ABE: Not that I can think of.
JUDITH: Anything coming up this week I should know?
ABE: Just what I said before, you know, about Charlie, and maybe volunteering.
JUDITH: Okay.

Next, you'll continue to find out what clients accomplished on their Action Plans.

JUDITH: Can we talk about your Action Plan? Do you have it with you?
ABE: Yeah. (*Pulls it out; Judith pulls out her copy too.*)
JUDITH: Were you able to read your therapy notes twice a day?
ABE: Maybe 90% of the time.
JUDITH: That's good.

Next, I ask Abe to read his therapy notes aloud and tell me how much he agrees with them. Then I check to see if he gave himself positive reinforcement, and we continue with the Action Plan review.

JUDITH: Did you give yourself credit when you read the therapy notes?
ABE: Yeah.
JUDITH: Good. (*looking at the Action Plan*) Let's see, did you get out every day?
ABE: Uh, huh. I also went to my daughter's house and babysat Saturday night.
JUDITH: Did your daughter appreciate that?
ABE: Yeah, and her husband too. Their babysitter cancelled at the last minute.
JUDITH: Might this be something you could offer to do again?

ABE: Yeah, I probably should.
JUDITH: Should we put that on your Action Plan?
ABE: Maybe put it as optional.
JUDITH: Okay. (*pause*) And did you give yourself credit?
ABE: Yeah. It was good I did it. It helped them out, and it was better than just sitting around with nothing to do at home.

We continue to review Abe's Action Plan. I give him positive reinforcement, ask about the meaning of his positive experiences, and discuss whether to continue a given Action Plan item in the coming week. He commits to continuing to get out of his apartment daily. During our discussion, I'm also alert for new agenda items that might take priority over the goals and issues we have already identified.

Prioritizing the Agenda

Next, you'll list the issues or goals on the agenda. If there are too many items, you and the client will collaboratively prioritize them and agree to move the discussion of less important items to a future session. You may also find out whether clients want to spend about an equal amount of time on each item or primarily talk about one agenda topic.

JUDITH: Okay, can we prioritize the agenda now? You mentioned you have a goal to do hard stuff in your apartment, maybe to do some work for Charlie, and to decide whether to volunteer even though you're tired. Which one do you want to start with?
ABE: Charlie.
JUDITH: Good. (*pause*) Should we definitely leave time to talk about getting stuff done and the volunteering?
ABE: Definitely about getting stuff done at home. It's okay if we don't get to talk about volunteering this week.
JUDITH: Should we divide the time about 50-50 between Charlie and your apartment?
ABE: That sounds fine.

THE MIDDLE PART OF THE SESSION

Next, you'll work on the issue or goal that is of greatest importance to the client. At times, though, you may take the lead in suggesting the agenda item to start with, especially when you judge that a *particular* issue should take precedence: "Is it okay with you if we start with _____?"

In traditional CBT, you usually collect data about a problem that has already occurred and conceptualize the client's difficulties according to the cognitive model. In a recovery-oriented approach, you're more likely to ask clients what steps they want to take in the coming week toward achieving a goal (the flip side of a problem), and you'll use the cognitive model to conceptualize obstacles that could get in the way of taking these steps (Beck et al., in press). In both approaches, you'll collaboratively decide on which part of the cognitive model you will begin working on

- the situation that has already occurred or a potential obstacle to taking steps toward a goal,
- the automatic thoughts associated with the situation/obstacle, and/or
- the reaction (emotional, behavioral, physiological) associated with the automatic thoughts.

You'll choose an intervention, provide a rationale, elicit the client's agreement, implement the intervention, and measure its effectiveness. In the context of discussing either issues or goals on the agenda, you'll be teaching clients skills and setting new Action Plans. You will also make periodic summaries to help you and the client recall what you've been doing in this part of the session. In discussing the first issue (and subsequent issues), you will interweave your therapy objectives as appropriate.

Abe and I first discuss whether he should take Charlie up on his offer of doing some construction work. I ask Abe about his concerns. His automatic thought is "I won't have enough stamina for a full workday." I teach him two questions to evaluate his thinking: "What makes me think this thought is true? What makes me think it isn't true, or not completely true?" The evaluation showed that Abe was probably right. We discuss his options: asking Charlie either if he could work for half a day or if he could

keep Abe in mind for a future construction job. Abe chooses the latter option, and we role-play what he can tell Charlie.

Then we discuss Abe's second goal and proceed in the same way. It turns out that the "hard stuff" was mostly about sorting a large pile of mail, paying bills, and completing insurance forms. To address the obstacles that could get in the way in the coming week, we follow these steps:

1. I collect data about the problem and ask Abe what thoughts he believes might interfere with doing these tasks.
2. I summarize his difficulty in the form of the cognitive model, evaluate his automatic thoughts, and record good responses to them.
3. We do problem solving (decided to just sort mail this week) and skills training (sorting mail into four piles).
4. We collaboratively set an Action Plan item.
5. We agree that Abe will set a timer, as we're sitting in the office, to remind him to start the mail the next morning.
6. We do covert rehearsal because Abe is still uncertain that he'll be able to get started on the task.
7. I ask Abe to imagine having completed the task.

JUDITH: Abe, can you imagine that it's tomorrow, just before lunch? You've been brave, tackling the stack of mail and you finished it. You're sitting at the dining room table, looking at the four piles you've sorted the mail into: the "keep" pile, the "do-something-with" pile, the "throw-away" pile, and the "not-sure-what-to-do" pile. (*pause*) How are you feeling as you're sitting there?

ABE: Relieved. Nervous about the "do-something-with" pile and the unsure pile, but you said we could talk more about them next week.

JUDITH: What are you saying to give yourself credit?

ABE: That it's good I finally did it.

JUDITH: Are you proud of yourself?

ABE: Yes … but I should have done it sooner [automatic thought].

JUDITH: How would you like to answer that thought?

ABE: Like you said. The depression has gotten in the way.

JUDITH: Exactly. What does it say about you that even though you're still really depressed, you got yourself to sort the mail?

ABE: I guess that I can do some things that I thought I couldn't.

JUDITH: Oh, that's so important. Can we write that down for your therapy notes?

Periodic Summaries

You'll summarize in three ways throughout sessions. One way is with the content. Clients often describe an issue with many details. You'll summarize what they've said in the form of the cognitive model to make sure you've correctly identified what is most important to them and to present it in a way that is clearer and more concise. You'll use your clients' own words as much as possible, both to convey accurate understanding and to keep the key difficulty or goal activated in their mind:

> "Let me make sure I understand, Abe. When you thought about sorting the mail this week, you thought, 'I can't face doing this,' and you felt really down and so you've been avoiding this job. (*pause*) Is that right? (*pause*) Did you feel any other emotion or have any other automatic thoughts?"

I summarize using Abe's actual words. If I had paraphrased, I might have done so incorrectly and probably reduced the intensity of the automatic thought and emotion. Then our subsequent evaluation of the thought might have been less effective. And when you substitute your words, clients may perceive that they haven't been accurately understood. You'll often ask clients to make a second kind of summary after you've finished discussing an issue or goal, to check on their understanding and reinforce important learning—for example: "Can you summarize what we just talked about? [or 'What do you want to be sure to remember?']"

When clients do a good job of summarizing, you or they should record this summary so they can read it daily as part of their Action Plan. You'll make a third kind of summary when you've finished a section of a session, so clients have a clear understanding of what has just been accomplished and what comes next: "Okay, so far we've talked about _____ and _____. Next, should we talk about _____?"

FINAL SUMMARY, CHECK ON ACTION PLAN, AND FEEDBACK

Final Summary

The goal of the final summary is to focus the client's attention on the most important points of the session in a positive way. You also see whether there seems to be any problem with fulfilling the Action Plan. In early sessions, you'll generally be the one to summarize.

JUDITH: Well, we have just a few minutes left. I'd like to summarize what we covered today, and then I'll ask you for your reaction to the session.
ABE: Okay.
JUDITH: It sounds like you felt a little better this week, and it seems to be due to reading your therapy notes, recognizing that some of your depressed thinking isn't true, being more active, and giving yourself credit. You did a lot of things to take control of your life and your activities and your mood. You're also starting to question your automatic thoughts and not immediately buy into them. (*pause*) Is that right?
ABE: Yeah.
JUDITH: Anything else to add to that?
ABE: No, I don't think so.

CLINICAL TIPS

As clients progress, you may ask *them* to summarize the most important points. Summarizing is much more easily accomplished if the client has recorded good notes during the session. You might say, "We just have a few minutes left." Then you can ask:

"What did you think was most important about today's session?" or "What do you think is going to be most important for you to remember this week? You can look at your notes."
"What did you learn?"

Check on Action Plan

Next, I review what we discussed Abe would do before our next session. First, I list items he has already been working on for the past few weeks.

But we've added a couple more items at this session, and I want to make sure he's highly likely to do them and doesn't feel overwhelmed.

JUDITH: Okay, can we look at your Action Plan? How likely are you, every day, to read your therapy notes, get out of your apartment, and keep your credit list?
ABE: 100%.
JUDITH: How about talking to Charlie? That's a onetime thing.
ABE: 100%. I will.
JUDITH: Sorting the mail? You can do it all at once or spread it out.
ABE: I think I can do it.
JUDITH: If you're not sure, should we make it optional? Or set a time limit on it, say, 10 minutes?
ABE: No, no, I'll do it.
JUDITH: And get tickets and take your grandsons to a baseball game? That's another onetime thing.
ABE: Yeah, I will.
JUDITH: 100%?
ABE: Yes.
JUDITH: And finally, when you recognize an automatic thought, how likely are you to ask yourself, "What makes me think this thought is true?" And also "What makes me think this thought is not true, or not completely true."
ABE: I can do that. The rubber band will remind me.
JUDITH: Does this all seem like too much to do?
ABE: (*Thinks.*) No, I've already been doing a lot of it.

Feedback

Following the final summary, you'll elicit feedback. By this time in our treatment, I was pretty sure that Abe would give me negative feedback if he had any. So I ask just one question: "What did you think about the session today?" For the first few sessions, I added these questions: "Was there anything I said that bothered you?"; "Anything you think I got wrong?"; "Anything you want to do differently next time?" Abe was already socialized to fill out a Feedback Form in the reception area, so I didn't need to remind him to do it.

SUMMARY

The structure outlined in this chapter provides an efficient way to accomplish the work of the session. Although various elements have been separated for clarity, many CBT therapists interweave them. Therapists also interweave their agenda items as they apply to the client's agenda items. The following chapter discusses problems in instituting the structure and how structure may need to be varied for an individual client.

REFLECTION QUESTIONS

What do you think will be the most difficult part of structuring a session? Why? What are three types of periodic summaries that are important in sessions, and why is each important?

PRACTICE EXERCISE

Ask a peer, colleague, friend, or family member to do a role play with you. Prepare an Action Plan that you will review toward the beginning of the session. Do the following:

1. Conduct a mood check (0–10).
2. Set an initial agenda.
3. Request an update and review the Action Plan from the previous week.
4. Discuss agenda item 1.
5. Ask client to summarize what you discussed and write down therapy notes.
6. Collaboratively set additional items for the Action Plan, if relevant.
7. Elicit a final summary and feedback.

11

PROBLEMS IN STRUCTURING SESSIONS

Many clients become easily socialized to the usual structure of sessions. Educating clients about the structure and providing a rationale may be enough. But there are certainly times when you *shouldn't* follow the usual structure. In this chapter, you'll find the answers to these questions:

- How do you conceptualize difficulties in structuring sessions?
- What are common problems for each segment of a typical therapy session?
- How can you solve these problems?
- When should you deviate from the agenda?
- What can you do when clients are distressed toward the end of a session?

GENERAL DIFFICULTIES IN STRUCTURING

When you become aware of a problem, ask yourself:

> "What is the specific problem? What is the client saying or not saying that's a problem? Or what is the client doing or not doing?"
> "Do I have any responsibility for this problem?"
> "How do I conceptualize why this problem arose?"
> "What should I do about it?"

If you've correctly diagnosed the client and developed a sound treatment plan but still have difficulties in structuring sessions, check on the following:

- Have you gently interrupted the client to direct the session?
- Have you socialized the client into the structure and process of treatment?
- Is the client sufficiently engaged in treatment?
- Is the therapeutic relationship strong enough?

Therapist Cognitions

If you are a novice therapist or a therapist experienced in a less directive modality, you may have interfering cognitions about gently interrupting clients and implementing the standard structure. Monitor your discomfort and identify your automatic thoughts during and between sessions. Here are some typical ones:

"I can't structure the session."
"[My client] won't like the structure."
"She can't express herself concisely."
"He'll get mad if I'm too directive."
"I'll miss something important."
"I shouldn't interrupt her."
"He won't do Action Plans."
"She'll feel invalidated."

If you're struggling, evaluate and respond to your thoughts so you can experiment with implementing the standard structure at the next session. I strongly recommend that you practice structuring sessions in role plays. Then, you can structure a client session as a behavioral experiment to see if your thoughts are accurate.

Interrupting the Client

For therapy to proceed most efficiently, you need to use gentle interruption. In one of our sessions, Maria starts talking about holiday

plans and then brings up other problems.

MARIA: And then, I couldn't believe it, but my sister told me—told me!—that I had to go help out Mom. She knows that I can't do that. I mean, my mother and I have never gotten along. If I go over, she'll just bombard me with stuff to do. And she'll criticize me. I just can't take any more criticism. I get it all day at work and …

JUDITH: Can I interrupt you for a minute? I want to make sure I understand what's been going on. We started talking about holiday plans and what you could do and then you described some other problems. Which do you think would be most important to work on? Holiday plans, your sister, mom, or work?

Sometimes clients become upset when you interrupt. When they do, positively reinforce them for telling you. Then apologize for making a mistake. (You overestimated how much interruption your client could tolerate.) Next, negotiate with the client, as I do with Maria below.

JUDITH: [interrupting Maria for the third time] Sorry to interrupt. How did you feel when he did that?

MARIA: (*in irritated tone of voice*) You're interrupting me again.

JUDITH: Oh, it's good you told me that. You're right. I'm sorry. I *have* been interrupting you too much. (*pause*) How does this sound? You tell me whatever you think is most important for me to know for the next 10 minutes or so, and I won't interrupt at all. Then I'd like to summarize what you said because it's important to me that I understand you correctly. (*pause*) Then maybe we can choose one issue to focus on next.

Clients like Maria often spontaneously tell you that you're interrupting too much. Other clients may tell you after you note an affect shift and ask them what's going through their minds. When you suspect that clients have had a negative reaction to interruptions but are reluctant to tell you, you can offer a hypothesis: "I was wondering whether you thought I was interrupting you too much?"

Socializing the Client

A second common difficulty in maintaining the prescribed structure can arise if you don't adequately socialize clients. Clients who are new to CBT don't know in advance that you would like them to *briefly* report on the week, describe their mood, and name agenda items. Asking clients to think about the items on the Preparing for Therapy Worksheet (Figure 10.3, p. 178) should help.

Clients also don't know that you will ask them to summarize important points of your discussions, provide feedback during and at the end of sessions, remember session content, and consistently do daily Action Plans. In addition, you are essentially teaching clients certain skills—and also a new way of relating to you (for those who have been in another type of therapy)—or a new way of relating to their difficulties so they can adopt a more objective, problem-solving orientation. In the first therapy session, you should tell them why you're structuring the session, describe each session element and then provide a rationale and monitor with gentle, corrective feedback.

Engaging the Client

A third common difficulty arises when clients have dysfunctional beliefs that interfere with their ability to commit to working in treatment. They may not have clear goals that they really want to achieve. They may have unrealistic hopes that they will somehow get better just by showing up to therapy sessions without doing the work of therapy. They may feel hopeless about their ability to solve problems, affect their life, or change. They may even fear that if they get better, their life will get worse in some way (e.g., they will lose you as a therapist or have to return to work). You need to be aware of clients' shifts in affect during the session so you can ask them for their cognitions. Then you'll help clients respond to their unhelpful thinking so they'll be more amenable to the structure and tasks of treatment.

Addressing Dysfunctional Cognitions

A fourth common difficulty involves clients' unwillingness to conform to the prescribed structure because of their perceptions of and dysfunctional beliefs about themselves, about therapy, or about you. I notice a negative

affect shift when I describe the session structure to Maria in our first therapy appointment.

JUDITH: What just went through your mind when I described what our sessions would be like?
MARIA: I'm not sure I'm comfortable with it. My old therapist just let me keep talking about whatever was on my mind.
JUDITH: Did you feel that helped you get over your depression?
MARIA: (*Thinks.*) Well, no, not really. That's why I stopped seeing him after a couple of years.
JUDITH: Here's my concern. If I do exactly what he did, I think we're going to have the same outcome. (*pause*) How would you feel about trying it a different way? You might find that it's actually a lot better for you. And if you don't, we can always change what we're doing.
MARIA: (*hesitantly*) I guess that's okay.
JUDITH: Good. Let's give it a try, and I'll make sure to ask you partway through today and at the end how it feels to you.

At the other end of the spectrum, you may allow the client to dominate and control the flow of the session—initially. With most clients, however, you will negotiate a compromise satisfactory to both of you, and you will try, over time, to move the client toward the standard structure.

CLINICAL TIPS

How do you determine whether the difficulty in adherence to session structure is due to faulty socialization or reluctance in complying? You first intervene by further socializing clients to the customary structure and by monitoring their verbal and nonverbal responses. If it's simply a problem in socialization, clients' responses are fairly neutral (or perhaps slightly self-critical), and subsequent compliance is good.

JUDITH: Can I interrupt for a moment? Can we get back to what happened when you called your friend?
ABE: Oh, sure.

When clients react negatively, they have undoubtedly perceived your request in a negative way, and you need to switch gears.

MARIA: That reminds me. I forgot to tell you what my mother told me I had to do.
JUDITH: Should we finish talking about David first?
MARIA: (*irritably*) But this thing with my mother is really upsetting.
JUDITH: Okay. We can talk about your mother. I just want to make sure that it's okay if we don't have time to get back to talking about David today.

MARIA: Yeah, the thing with David can wait.

Problems can also arise if you impose structure in a controlling or demanding fashion. If clients are reluctant to provide you with honest feedback, you may not know you've made this mistake. It will be important for you to review a recording of the session—and even better, if a peer, colleague, or supervisor reviews it too. Then you can model apologizing and remedy the problem at the next session. You might say: "I think I came across as too heavy-handed last week. I'm sorry, I do want to make sure that you agree with how the session goes."

COMMON PROBLEMS IN STRUCTURAL PARTS OF SESSIONS

You could potentially run into difficulties for each part of the session, including

- The mood check,
- setting the agenda,
- eliciting an update,
- reviewing the Action Plan,
- discussion of agenda items, and/or
- ending the session.

The most common problems in each of these areas are described below.

Difficulties in Doing the Mood Check

Common problems involve clients' failure to fill out forms, annoyance with forms, or difficulty in subjectively expressing (in a concise manner) their general mood during the week. If the difficulty is simply faulty socialization related to completing the forms, you can ask clients whether they remember and agree with the rationale for filling them out and

determine whether there's a practical difficulty that needs to be resolved (e.g., insufficient time, forgetting, or a problem in literacy).

Negative Reactions to Forms

When clients are annoyed by the request to fill out forms, you can ask for their automatic thoughts when thinking about or actually filling them out, or you can ask for the significance of the situation:

> "What's the worst part about filling them out?" or
> "What does it *mean* to you that I've asked you to fill out these forms?"

You can then empathically respond to clients' concerns, help them evaluate relevant thoughts and beliefs, and/or do problem solving. These responses are provided in the three examples below.

CLIENT 1: These forms don't really seem to apply to me. Half of the questions are irrelevant.
THERAPIST: Yes, I know. But actually, they're helpful to me—I can look at them quickly and get the overall picture, and not bother you with lots of questions. Would you be willing to fill them out again next week, and we can talk more about them then if they still bother you?

In the next example, the client clearly expresses his annoyance through his choice of words, tone of voice, and body language.

CLIENT 2: These forms are a waste of time. Half the questions are irrelevant.
THERAPIST: What's the worst part about filling them out?
CLIENT 2: I'm busy. I have a lot to do. If my life fills up with meaningless tasks, I'll never get anything done.
THERAPIST: I can see you feel pretty irritated. How long does it take you to fill them out?
CLIENT 2: … I don't know. A few minutes, I guess.
THERAPIST: I know some of the items don't apply, but actually they save us time in our session because I don't have to ask you lots of questions

myself. Could we try to problem-solve and see where you could fit in the time to do them?

CLIENT 2: (*Sighs.*) I guess it's not that big a deal. I'll do them.

Here I avoid directly evaluating the accuracy of the client's automatic thoughts because he is annoyed and I sense that he will perceive such questioning in a negative way. Instead, I provide a rationale and help the client realize that the task is not as time consuming as he has perceived it to be. In a third case, I judge that further persuasion to fill out forms will negatively affect our tenuous therapeutic alliance.

CLIENT 3: (*in an angry voice*) I hate these forms. They don't apply to me. I know *you* want me to fill them out, but I'm telling you, they're worthless.

THERAPIST: Let's skip them, then, at least for the time being. I *would* like to get a clear idea of how you've been feeling during the week though. Maybe you could just rate your depression on a 0–100 scale, where 0 is not feeling depressed at all and 100 is the most depressed you've ever felt. Would that be all right?

Difficulty Expressing Mood

A different problem involves clients' difficulty in subjectively expressing their mood, either because they do not do so concisely or because they have difficulty labeling their moods. You might gently interrupt, and either ask specific questions or demonstrate to them how to respond.

If clients elaborate at length about their mood, socialize them to give a concise description.

THERAPIST: Can I interrupt you for a moment? I *do* want to hear more about _____ in a few minutes, but first I just need to know whether you've generally felt better, worse, or the same compared to last week.

CLIENT: Worse.

THERAPIST: More anxious? More sad? More angry?

CLIENT: Angry, I guess.

When clients have difficulty labeling their moods, you might respond differently: "It sounds like it's hard to pin down how you've been feeling. Maybe we should put on the agenda 'identifying feelings.'" During the session, you might use the techniques described in Chapter 13 to teach clients to specify their mood.

Attribution of Change in Mood to External Factors

Sometimes clients attribute positive changes in their mood to external factors. For example, they might say, "I felt better because the medication started working/my boss was out sick/my partner was nicer to me." You might then suggest, "I'm sure that helped, but did you also find yourself *thinking* differently or *doing* anything that was different?"

Worsening of Mood

Also seek clients' attributions when their mood has become worse: "Why do you think you're feeling worse this week? Could it have anything to do with your thinking, or with the things you did or didn't do?" In this way, you subtly reinforce the cognitive model and imply that clients can take some control over how they feel.

CLINICAL TIPS

You could have clients who say, "Nothing can improve my mood." It might be helpful to create a chart such as the one in Chapter 7, page 130. Recognizing that there are things that make them feel better or worse can help reinforce the notion that clients can affect their mood. Through guided discovery, you can help them see that avoidance, isolation, and inactivity generally increase their dysphoria (or at least do not improve it), while engagement in certain activities (usually that involve interpersonal interaction or that have the potential for pleasure or mastery) can lead to an improvement in their mood, even if initially the change is small.

Difficulties in Setting the Agenda

Typical difficulties in setting the agenda arise when clients

- ramble,
- fail to contribute, and/or

- feel hopeless or overwhelmed.

Rambling when Contributing to the Agenda

Sometimes clients digress or are long-winded. A gentle interruption and summary can help: "Can I interrupt for a moment? It sounds as if you have goals this week in terms of your dad and work. Is there anything more important than those two things?"

Failing to Contribute to the Agenda

Some clients don't name problems or goals for the agenda because they truly don't know what to say, they are doing really well, or they're not adequately socialized. If they're not sure what should go on the agenda, you can ask them one or more of the following questions:

> (*taking out a copy of the client's goals*) "Is there something on this list you'd like to talk about?"
> "How would you like the next few days to be better?"
> "How do you want to feel next week when you come in? What will you need to do this week to feel that way?"
> "Do you want to talk about _____ [a goal] or _____ [a specific issue]?"
> "When was the past week most difficult for you?"

You can also look at the symptom scales they filled out on that day and see which ones are elevated.

If they don't need further help in working toward their goals, you can focus on relapse prevention (Chapter 21).

Below, I illustrate two occasions, in Sessions 2 and 3, where I have some difficulty setting an agenda with Maria.

JUDITH: What would you like the goal for this session to be?
MARIA: … I don't know.
JUDITH: Is there a particular goal you want to work toward? How would you like your life to be better this week?
MARIA: (*Sighs.*) I don't know.
JUDITH: Are you feeling kind of hopeless?
MARIA: Yeah. Last week was really bad.

JUDITH: [providing a multiple choice] Do you think you generally felt worst in the morning, the afternoon, or in the evening?
MARIA: Mornings, I guess.
JUDITH: Okay, can we put "mornings" on the agenda to see if there's anything we can do to make them a little better?
MARIA: All right.

At the end of the session, I'll ask Maria to add an Action Plan item to her list: to think about what issues or goals she wants help with at the next session.

Sometimes clients don't contribute to setting the agenda because they put a special negative *meaning* on contributing. You can ask for their automatic thoughts or for what it means to them that you've asked them to name agenda items. When Maria returns to our third session, her update suggests there are important issues for us to go over. But she doesn't put them on the agenda.

JUDITH: Were you able to think about what goals you want to work on?
MARIA: (*in a slightly annoyed tone*) I thought about it. But I didn't come up with anything.
JUDITH: How were you feeling when you were thinking about it? Annoyed?
MARIA: Maybe a little.
JUDITH: What was going through your mind?
MARIA: I'm just not sure that this therapy is right for me.
JUDITH: [positively reinforcing Maria] It's good you told me that. Do you have a sense of what might help you more?
MARIA: Sometimes I just need to talk to get things off my chest.
JUDITH: So when I ask you to set the agenda, do you feel kind of hemmed in?
MARIA: Yeah, I guess I do.
JUDITH: Let's figure out together how to make it better. Would you like to skip setting the agenda at the very beginning of our sessions? How would it be if you came in and talked about whatever is on your mind for the first few minutes. Then we can pick whatever feels most important to you to work on for the next part of the session. (*pause*) Does that sound okay?
MARIA: It sounds better.

JUDITH: Is there anything else that bothers you about this therapy?
MARIA: No, I don't think so.
JUDITH: Could you be sure to let me know if you think of something?
MARIA: Okay.

Maria's response is unusual. Most clients are much more easily socialized into agenda setting. But in this case, I recognized that pushing Maria further might alienate her, so I demonstrate my desire to collaboratively "fix" the problem. She needs more flexibility in session structure initially, but I move her toward a more standard structure as soon as I can.

Clients who ramble during agenda setting or launch into a detailed account of an issue instead of naming it usually just require further socialization.

JUDITH: (*gently interrupting*) Can I interrupt you for a moment? Should we call this goal "reconnecting with your brother"?
ABE: Yes.
JUDITH: Good. Can you tell me the name of any other issue or goal you'd like to work on?

Occasionally clients persist in the next session in *describing* issues rather than just *naming* them during agenda setting. If so, you can ask them to jot down their agenda topics as part of their Action Plan.

Feeling Hopeless and Overwhelmed

A third problem in agenda setting arises when clients feel hopeless and overwhelmed. Here I try to get Maria into a problem-solving mode.

JUDITH: Maria, what goals do you want to work toward today?
MARIA: (*Sighs.*) I don't know … I'm so overwhelmed. I don't think any of this is going to help.
JUDITH: You don't think talking about your problems and goals in here will help?
MARIA: No. What's the use? I mean, you can't fix the fact that I owe too much money and I'm so tired I can't even get out of bed most mornings—not to mention the fact that my apartment is out of control.

JUDITH: Well, it's true that we can't fix everything at once. And you do have real problems that we need to work on together. Now, if we just have time to work on *one* thing today, which do you think will help more than the others?

MARIA: I don't know … the tiredness, maybe. If I could sleep better, maybe I could get more done.

In this case, I give Maria the message that her problems are real, that they can be worked on one by one, and that she need not work on them alone. Asking her to make a forced choice helps her select a problem and become oriented toward problem solving. Had Maria refused to make a choice, I might have tried a different tactic:

> "It sounds like you're feeling pretty hopeless. I don't know for sure that working together will make a difference, but I'd like to try. (*pause*) Would you be willing to try? Could we talk about the tiredness for a few minutes and see what happens?"

Acknowledging her hopelessness and my inability to guarantee success increases Maria's willingness to experiment with problem solving.

Difficulties in Eliciting an Update

A common difficulty arises when clients provide too detailed an account of their week or speak at length in an unfocused way. After a few such sentences, you should gently jump in:

> "Can I interrupt you for a moment? Right now, I just need to get the big picture of how you've been feeling. Could you just tell me about your week in two or three sentences? Was it generally a good week? A bad week? Or did it have its ups and downs?"

If clients continue to offer details instead of the broader picture, you might demonstrate what you are looking for:

> "It sounds to me like you're saying, 'I had a pretty hard week. I had a fight with a friend, and I was really anxious about going out, and I had

trouble concentrating on my work.' Is that right?"

Some clients do understand and are capable of providing a succinct review but do not *choose* to do so. If you have data to suggest that questioning clients about their reluctance to comply could damage the relationship, you may initially allow them to control the update portion of the session. Such data might include clients' verbal and/or nonverbal reactions to your prior attempts at structuring, their direct statements of strong preferences in the therapeutic process, or their reports of a strong reaction in the past when they have perceived others as controlling or dominating. Extreme reactions to structuring are not common, however. Usually you can matter-of-factly elicit reasons for clients' reluctance, and then problem-solve. After asking clients to review their week more concisely and noting a negative shift in affect, you might say, "When I just asked you to give me the big picture, what went through your mind?" Having identified clients' automatic thoughts, you might then

- help them evaluate the validity of their thoughts,
- use the downward arrow technique (see pp. 291–292) to uncover the meaning of their thoughts, and/or
- make an empathic statement and move straight to problem solving, as below:

"I'm sorry you felt I cut you off again. I can see you have a lot on your mind, and I *would* like to hear it. (*pause*) Do you want to continue with the update now, or should we put 'update of week' on the agenda? I just want to make sure I know all the issues you want to talk about today."

This latter choice is usually better than helping clients evaluate their thoughts at the moment if they are particularly annoyed. By expressing your concern and willingness to compromise, you can often modify clients' perception that you are being too controlling.

Difficulties in Reviewing the Action Plan

A typical problem arises when therapists, in their haste to get to clients' agenda issues, fail to ask clients about their Action Plan. You are more likely to remember to ask about Action Plans if you keep it as a standard agenda item and if you review your therapy notes from the previous session before clients enter your office. The opposite problem sometimes arises when the therapist reviews Action Plans (unrelated to the client's distress that day) in too much detail before turning to the client's agenda topics.

Difficulties in Discussing Agenda Items

Typical problems here include

- unfocused or tangential discussion,
- inefficient pacing,
- failing to make a therapeutic intervention, and/or
- difficulty in knowing how to solve a client's problem.

Unfocused Discussion

This problem usually results when you fail to structure the discussion appropriately through gentle interruptions (guiding the client back to the issue at hand); when you fail to emphasize *key* automatic thoughts, emotions, beliefs, and behaviors; and when you fail to summarize frequently. Below, I summarize many things Abe told me in just a few words and redirect him to identify his automatic thoughts.

JUDITH: Let me just make sure I understand. Your mother said some unkind things to you on the phone. This reminded you of other interactions you've had with her, and you began to get more and more upset. Last night you called her again, and she began to criticize you for not living up to your responsibilities. Is that right?

ABE: Yeah.

JUDITH: What went through your mind as she said, "You're not living up to your responsibilities"?

Inefficient Pacing

Pacing is often a problem when you take too much time or too little time discussing an agenda item. Some therapists overestimate how many issues or goals can be discussed during one therapy session. It is preferable to prioritize and then to specify two items (or possibly a third) to be discussed during a session, especially if you're a novice CBT therapist. Together you and the client should keep track of the time and collaboratively decide what to do if time is running short. In practical terms, it's advisable to have two clocks (one for each of you to easily see) so you can encourage clients to monitor the passage of time along with you. You might say:

> "We have only 10 minutes left before we have to start finishing up. Would you like to continue talking about this issue with your neighbor? Or we could finish in the next minute or two so we have time to discuss your getting more done around your apartment."

Alternatively, you can suggest how to spend the time and see if the client agrees with you:

> "We have only 10 minutes left before we have to start finishing up. I think what we're talking about is really important. Is it okay if we postpone talking about _____ until our next session?"

Failing to Make a Therapeutic Intervention

Much of the time, merely describing a problem or goal or identifying dysfunctional thoughts or beliefs will *not* result in the client's feeling better. You should be conscious of helping clients (during the session itself) respond to their dysfunctional cognitions, solve or partially solve a problem or address an obstacle to a goal, and set up an Action Plan. Throughout the session, you should ask yourself:

> "How can I help the client feel better by the end of the session?"
> "How can I help the client have a better week?"

Difficulty with Problem Solving

You may encounter situations in which you don't know how to help a client solve a problem or resolve an obstacle. There are several things you can do:

- Find out what the client already tried to do and conceptualize why it didn't work. You may be able to modify the solution or modify thoughts that got in the way.
- Use yourself as a model. Ask yourself, "If I had this problem or goal, what would I do?"
- Ask the client to name another person (usually a friend or family member) who could conceivably have the same kind of problem or goal. What advice would the client give him or her? See whether that advice could apply to the client.
- Ask the client if he or she knows someone who could help with the problem or goal.

If you're stuck, postpone the discussion: "I'd like to think more about this issue this week. Could we put it on the agenda to talk more about next week?"

DEVIATING FROM THE AGENDA

There are times when you *shouldn't* follow the agenda you and the client collaboratively set at the beginning of the session:

- If you find out that clients are at risk or they are putting others at risk, you'll need to address these problems immediately. Risky situations might involve the client's (or others') life, health, livelihood, employment, living situation, and so on.
- If you see that clients are so distressed by a problem that they can't focus on what you're currently discussing, you may need to talk about the distressing problem.
- If you assess that following the agenda will impair the therapeutic relationship, you'll need to collaboratively get back on track with clients.

- If an issue arises that is more pressing than the agenda items (or certain original agenda items turn out to be relatively unimportant or not time sensitive), you'll need to address a different problem or goal.

Clients usually go along with the structure you propose. But once in a while, clients object, especially if

- you haven't provided a strong enough rationale,
- you've come across as too controlling and noncollaborative,
- they believe that discussing the past early in treatment is essential, and/or
- they strongly prefer to spend the session talking freely about whatever comes in their mind.

What do you do? Above all, you need to engage clients so they will return to treatment for the next session. You may need to spend some time talking about what they think will help most. If you judge that trying to persuade clients to adhere to your agenda will endanger their engagement in treatment, especially early on, you might offer to split the therapy time. If they protest, you can spend the session doing what they want. At the next session, you'll find out whether doing so helped them feel significantly better during the week. If not, they may be more motivated to spend at least part of the session discussing what you think is important to help them feel better.

WHEN CLIENTS ARE DISTRESSED TOWARD THE END OF A SESSION

When clients are upset toward the end of a session because you haven't had enough time to fully discuss an issue, you can change the conversation to something more positive.

JUDITH: Maria, I can see you're still upset about this. Could we talk more about this at our next session? I don't want you to leave the session feeling this way.

MARIA: Okay.
JUDITH: Would it be all right if we talked about something lighter? Tell me about your nephew. What is he into these days?

As discussed in Chapter 4, make sure to positively reinforce clients whenever they give you negative feedback; then conceptualize and plan a strategy.

JUDITH: What did you think about today's session? Was there anything I got wrong? Or did I say anything that bothered you?
MARIA: I don't think you realize how hard it is for me to get things done. I have so many responsibilities and so many problems. It's easy for *you* to say I should just concentrate on my what's going well in my life and forget all about what's happening with my mother.
JUDITH: Oh, it's good you told me—and I'm sorry you got that impression. What I *meant* to get across was that I realize you are very distressed by the problem with your mother. I wish we had time to talk about that now. (*pause*) But meanwhile, was there something I said or did that made you think I was suggesting that you just *forget* all about it?

I clarified the misunderstanding, and we agreed to put the issue with Maria's mother on the agenda at our next session.

SUMMARY

Therapists at all levels of experience encounter difficulties in structuring sessions with particular clients. It's important to specify the problem and then conceptualize why the problem is happening. Careful review of your session tapes can be invaluable in identifying and then solving these problems. A more extensive account of how to conceptualize and modify problems clients present in session, along with videos of therapy sessions, can be found in an online course on personality disorders (*beckinstitute.org/CBTresources*).

REFLECTION QUESTIONS

Why is it important to interrupt clients at times? What automatic thoughts might you have that would get in the way of gently interrupting your clients? How can you respond to these thoughts?

PRACTICE EXERCISE

Do a role play (or create a transcript) in which a client becomes irritated when you interrupt him or her.

12

IDENTIFYING AUTOMATIC THOUGHTS

To review, the cognitive model suggests that the interpretation of a situation (rather than the situation itself), expressed in automatic thoughts or images, influences one's emotion, behavior, and physiological response. It's important to help clients respond to their unhelpful or inaccurate thoughts.

Certain events are almost universally upsetting, for example, a personal assault or rejection. People with psychological disorders, however, display biased thinking. They often see situations as much more negative than they really are. They may misconstrue neutral or even positive situations. By critically examining and responding to their thoughts, they often feel better. We especially want to address automatic thoughts that pose obstacles to attaining goals.

The rest of this chapter deals with negative automatic thoughts and answers these questions:

- What are the characteristics of automatic thoughts?
- How can you explain automatic thoughts to clients?
- How do you elicit and specify automatic thoughts?
- What does an extended cognitive model look like?
- What are different forms of automatic thoughts? What can you do when clients have difficulty identifying their automatic thoughts?
- How do you teach clients to identify their automatic thoughts independently?

CHARACTERISTICS OF AUTOMATIC THOUGHTS

Automatic thoughts are a stream of thinking that coexists with a more manifest stream of thought (Beck, 1964). These thoughts aren't characteristic only of individuals in psychological distress; they are an experience common to us all. Most of the time we are barely aware of these thoughts, although with just a little training we can easily bring these thoughts into consciousness. When we become aware of our thoughts, we may automatically do a reality check if we're not suffering from psychological dysfunction. This kind of automatic reality testing and responding to negative thoughts is a common experience. People who are in distress often don't engage in this kind of critical examination. CBT teaches clients tools to evaluate their thoughts in a conscious, structured way, especially when they're upset or engaged in unhelpful behavior.

Abe, for example, has to stay home to fix an active leak under the sink, so he can't attend his grandson's soccer game. He thinks, "Ethan will be so disappointed." His thinking then becomes more extreme: "I'm *always* letting him down." He accepts these thoughts as true and feels quite sad. After learning tools of CBT, however, he's able to use his negative emotion as a cue to identify, evaluate, and respond adaptively to his thoughts. In another situation, Abe was able to respond to a similar automatic thought in this way: "Wait a minute, her parents are going to be at there [at her dance recital]. She may be a little disappointed that I'm not. And it's not true that I'm always letting her down. I've gone to lots of her performances."

You seek to identify automatic thoughts that are dysfunctional—that is, those that

- distort reality,
- are associated with an unhelpful emotional and/or physiological reaction,
- lead to unhelpful behavior, and/or
- interfere with clients' sense of well-being and ability to take steps to reach their goals.

As we discussed in earlier chapters, it's vital to be alert to both verbal and nonverbal cues from clients so you can identify the most important (or "hot") cognitions—that is, important automatic thoughts and images that arise in the therapy session itself. These cognitions may be about the subject under discussion ("It's not fair that I have so much to do"). But they may be about the client ("I can't do anything right"), the therapist ("You don't understand me"), or the process of therapy ("I don't like giving feedback"). And they may undermine the client's motivation, sense of adequacy or worth, or concentration. Finally, automatic thoughts may interfere with the therapeutic relationship. Identifying automatic thoughts on the spot gives clients the opportunity to test and respond to their thoughts immediately, which facilitates the work in the rest of the session.

Dysfunctional automatic thoughts are almost always negative unless

- the client is manic or hypomanic ("It's a great idea to see how fast my car can go"),
- the client has narcissistic traits ("I'm superior to everyone"), and/or
- the client is giving him- or herself permission to engage in maladaptive behavior ("It's okay to binge drink because all my friends are doing the same thing").

Automatic thoughts are usually quite brief, and clients are often more aware of the *emotion* they feel as a result of their thoughts than of the thoughts themselves. Sitting in session, for example, clients may be somewhat aware of feeling anxious, sad, irritated, or embarrassed but may be unaware of their automatic thoughts until you elicit them. The emotions clients feel are logically connected to the *content* of their automatic thoughts. For example, Abe thinks, "Everything is such a mess. I'm so lazy"—and feels sad. Another time he thinks, "I should be visiting my mother more often"—and feels guilty. When he has the thoughts "What if I run out of money?" he feels anxious.

Sometimes clients are more aware of their unhelpful *behavior* than they are of the automatic thoughts that precede their action. Abe, for example, recognizes that he has avoided connecting with his friends and doing tasks around his apartment. This behavior is logically connected to the content of his automatic thoughts. When I ask him what was going through his mind in the first situation, he replies, "They might be critical of me for not

working." In the second, he thought, "I'll just mess up anything I try to do."

Clients may also be more aware of their physiological response than of their thoughts. Maria, for example, noticed feelings of tension, more than her automatic thoughts, when she was anxious.

Most automatic thoughts are associated with external situations (e.g., talking to a friend) or a stream of thoughts (e.g., thinking about an upcoming or a past event). But a wide range of both external stimuli and internal experiences can give rise to automatic thoughts. Clients can have thoughts about any part of the cognitive model:

- Their cognitions (thoughts, images, beliefs, daydreams, dreams, memories, or flashbacks),
- Their emotion,
- Their behavior, or
- Their physiological or mental experiences (e.g., strange ideas or a sense that their thoughts are racing).

Any of these stimuli may lead to an automatic thought (or series of automatic thoughts), followed by an emotional, behavioral, and/or physiological reaction. Here are some examples from Abe:

- When Abe thought, "I wish I never had to talk to my ex-wife again," he had an automatic thought about this thought: "I shouldn't think things like that."
- When Abe thought, "I'm so tired. I don't want to go to Max's soccer game," he then thought, "I'm a really bad grandfather for not wanting to go."
- When Abe had automatic thoughts in the form of memories about his marriage, he thought, "I wish I didn't always remember the worst parts of our life together."
- When Abe realized how hopeless and sad he was feeling, he thought, "I'm always going to feel this way."
- When Abe avoided going out to do errands, he thought, "I'm so lazy."
- When Abe became anxious about being late, his heart started beating fast and he thought, "What's wrong with me?"

In traditional CBT, we tend to focus on problematic situations from the past week, determining at which point clients were *most* distressed and what their automatic thoughts were. In a recovery orientation, we tend to

focus more on the thoughts clients predict will create an obstacle to taking steps in the coming week toward achieving their goal.

Clients may have distressing or unhelpful automatic thoughts

- *before* a situation, in anticipation of what might happen ("What if he's upset with me?"),
- *during* a situation ("She's thinking how poorly I'm doing this"), and/or
- *after* a situation, reflecting on what happened ("I never should have called him up").

EXPLAINING AUTOMATIC THOUGHTS TO CLIENTS

It's desirable to explain automatic thoughts by using the client's own examples. In the context of discussing a specific issue with a client, you will elicit the associated automatic thoughts and then provide psychoeducation.

JUDITH: [moving to the first agenda topic] Maria, should we talk about your goal of connecting better with your sister?
MARIA: Yes.
JUDITH: What do you want to do this week?
MARIA: (*Sighs*.) I really should ask her if she wants to have lunch.
JUDITH: How are you feeling?
MARIA: I don't know. Sad, down.
JUDITH: What's going through your mind?
MARIA: She's so lucky. I'll never be able to have a life like hers.
JUDITH: No wonder you're feeling sad. [providing psychoeducation] You just identified what we call an *automatic thought*: I'll never be able to have a life like hers. Everyone has these kinds of thoughts. They just seem to pop into our heads, even when we're trying to think about something else. That's why we call them *automatic*. (*pause*) Most of the time, they're very quick and we're much more aware of the emotion—in this case, you feel sad—than we are of our thoughts. (*pause*) When people are depressed like you are, it turns out that often

the thoughts aren't true, or not completely true. But we react *as if* they're true.

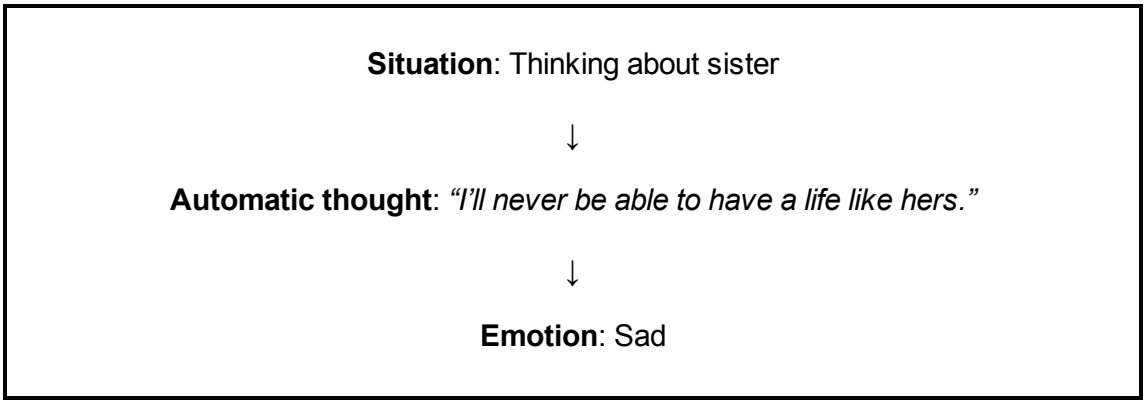
MARIA: Oh.

JUDITH: [checking on her comprehension] Can you tell me about automatic thoughts in your own words?

MARIA: I think what you're saying is that I have these quick thoughts, and because I'm depressed, they might not be true.

JUDITH: Exactly.

In the next part of the session, I write down the cognitive model for this automatic thought.



JUDITH: Let's get that down on paper. When you had the thought "I'll never be able to have a life like hers," you felt sad. Do you see how what you were thinking influenced how you felt?

MARIA: Uh-huh.

JUDITH: I'll be teaching you to identify your automatic thoughts when you notice your mood changing or you're doing something that's not helpful. That's the first step. We'll keep practicing it until it's easy. And you'll also learn how to *evaluate* your thoughts and change your thinking if it's not completely right.

ELICITING AUTOMATIC THOUGHTS

The skill of identifying automatic thoughts is analogous to learning any other skill. Some clients (and therapists) catch on quite easily and quickly.

Others need much more guidance and practice. The basic questions you ask clients are:

> "What [is/was/will be] going through your mind?"
> "What [are you/were you/will you be] thinking?"

You'll ask one of these questions

- when clients describe a problematic situation, emotion, behavior, or physiological reaction they had (often in the past week) or expect to have (often in the coming week); and/or
- when clients experience a negative shift in affect or exhibit an unhelpful behavior in the therapy session itself.

Eliciting Additional Automatic Thoughts

Continue questioning clients even after they report an initial automatic thought, to discover whether they have had other important thoughts.

JUDITH: [summarizing] So when you woke up yesterday morning with a hangover, you thought, "I never should have drunk so much last night." What else went through your mind?
MARIA: I can't believe I did that again.
JUDITH: Then what?
MARIA: I was thinking, "What's the point of even trying though. Nothing will ever get better."

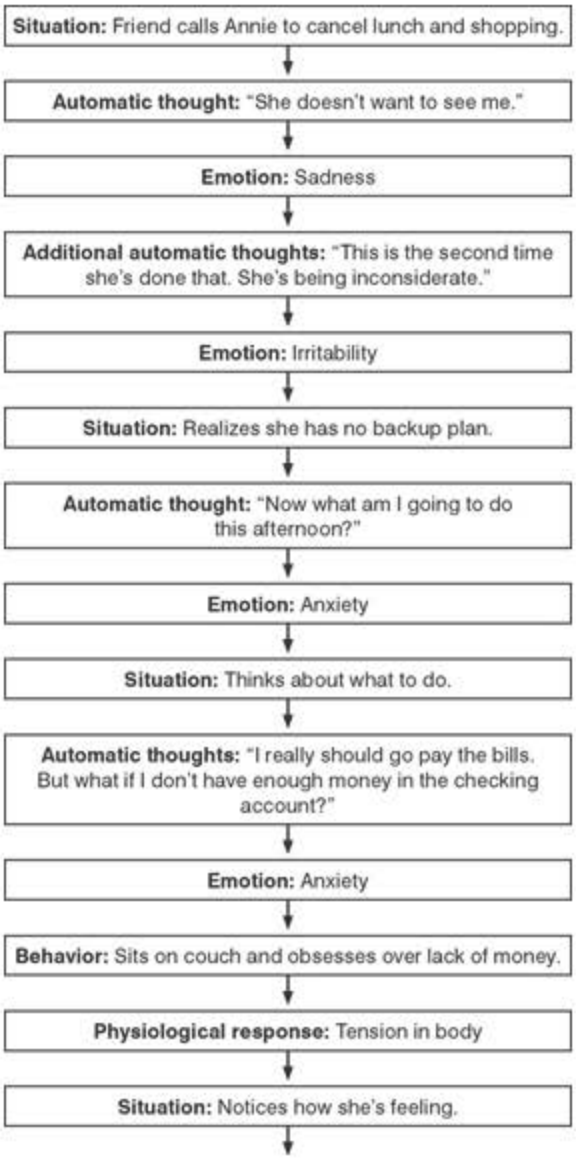
When clients express an automatic thought and an emotion, it's also important to see whether they experienced additional emotions. If so, they undoubtedly had another thought, or a stream of thoughts.

JUDITH: [summarizing] So you felt sad when you thought, "I've used up most of my savings." Did you feel any other emotion?
ABE: I think I felt anxious.
JUDITH: What was going through your mind that made you feel anxious?

ABE: I was thinking, “What’s going to happen to me? What if I can’t make rent? Am I going to wind up on the street?”

AN EXTENDED COGNITIVE MODEL

Clients sometimes have a series of automatic thoughts and reactions about a given issue, especially if the client ends up behaving in an unhelpful way, such as using an impulsive behavior. It’s important to record the many steps, from the initial trigger to the final reaction (which can take seconds to hours). Figure 12.1 demonstrates how Maria experienced an initial upsetting situation and then ultimately drank too much.


Situation: Friend calls Annie to cancel lunch and shopping.
Automatic thought: "She doesn't want to see me."
Emotion: Sadness
Additional automatic thoughts: "This is the second time she's done that. She's being inconsiderate."
Emotion: Irritability
Situation: Realizes she has no backup plan.
Automatic thought: "Now what am I going to do this afternoon?"
Emotion: Anxiety
Situation: Thinks about what to do.
Automatic thoughts: "I really should go pay the bills. But what if I don't have enough money in the checking account?"
Emotion: Anxiety
Behavior: Sits on couch and obsesses over lack of money.
Physiological response: Tension in body
Situation: Notices how she's feeling.

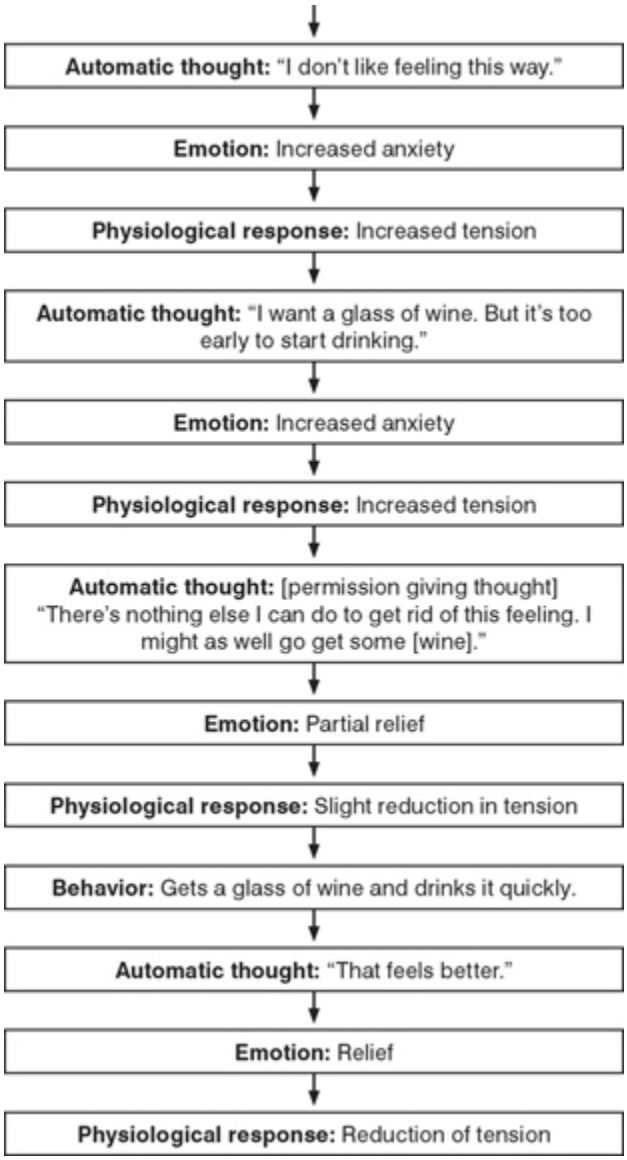

Automatic thought: "I don't like feeling this way."
Emotion: Increased anxiety
Physiological response: Increased tension
Automatic thought: "I want a glass of wine. But it's too early to start drinking."
Emotion: Increased anxiety
Physiological response: Increased tension
Automatic thought: [permission giving thought] "There's nothing else I can do to get rid of this feeling. I might as well go get some [wine]."
Emotion: Partial relief
Physiological response: Slight reduction in tension
Behavior: Gets a glass of wine and drinks it quickly.
Automatic thought: "That feels better."
Emotion: Relief
Physiological response: Reduction of tension

FIGURE 12.1. Example of an extended cognitive model.

Once you and clients have mapped out the extended scenario, you can show them all the places where they can learn to intervene *before* they engage in the dysfunctional behavior. Doing so usually makes them feel more hopeful about solving the problem.

FORMS OF AUTOMATIC THOUGHTS

Automatic thoughts are most commonly in verbal form. Sometimes, though, they're in the form of images (Chapter 20). And sometimes clients don't state their automatic thoughts outright. They may

- tell you their interpretations of their experiences,
- embed their automatic thoughts in discourse,
- express short phrases, and/or
- report automatic thoughts as questions.

If so, you need to guide clients to change their verbalizations so they're in a form that can be evaluated.

Differentiating Automatic Thoughts from Interpretations

When you ask for clients' automatic thoughts, you're seeking the *actual* words or images that go through their mind. Until they have learned to recognize these thoughts, some clients report *interpretations* (as Maria does below), which may or may not have been their actual thoughts.

JUDITH: When you saw the receptionist, what went through your mind?
MARIA: I think I was denying my real feelings.
JUDITH: What were you actually thinking?
MARIA: I'm not sure what you mean.

In this exchange, Maria reported an *interpretation* of what she was feeling and thinking. Below, I try again, by focusing on and heightening her emotion.

JUDITH: What feelings were you denying?
MARIA: I'm not sure.
JUDITH: [supplying an emotion opposite to the expected one to jog her recall] When you saw her, did you feel happy? Excited?
MARIA: No, not at all.

JUDITH: Can you remember walking into the office and seeing her? Can you picture that in your mind?
MARIA: Uh-huh.
JUDITH: (*speaking in the present tense*) What are you feeling?
MARIA: I don't know.
JUDITH: As you look at her, what's going through your mind?
MARIA: [reporting an emotion and a physiological reaction, instead of an automatic thought] I feel really anxious, my heart is beating fast, and I feel all jittery.
JUDITH: What are you thinking?
MARIA: What if she gives me a hard time again about not filling out the forms? [automatic thought]
JUDITH: Okay. Anything else?
MARIA: I guess I was thinking, "If she gives me a hard time, I'll have to leave."

Specifying Automatic Thoughts Embedded in Discourse

Clients need to learn to specify the actual words that go through their minds in order to evaluate them effectively. Following are some examples of embedded thoughts versus actual words:

Embedded expressions	***Actual automatic thoughts***
"I guess I was worried about what she would say to me."	"She's going to criticize me."
"I don't know if going to the boss would be a waste of time."	"It'll probably be a waste of time if I go."
"I couldn't get myself to start reading."	"I can't do this."

Again, you gently lead clients to identify the *actual* words that went through their mind.

JUDITH: So when you turned red, what went through your mind?
MARIA: I guess I was wondering if he thought I was this really strange person.
JUDITH: Can you remember the exact words you were thinking?
MARIA: (*puzzled*) I'm not sure what you mean.

JUDITH: Were you thinking, "I guess I was wondering if he thought I was this really strange person," or were you thinking something like "He probably thinks I'm really strange."
MARIA: Oh, I see; the second one.

Changing the Form of Telegraphic or Question Thoughts

Clients may report thoughts that are not fully spelled out. It's difficult to evaluate telegraphic thoughts, and you should prompt the client to express the thought more fully by asking for the *meaning* of the thought. For example, when Abe had the thought "Oh, no!" the meaning to him was "My ex-wife is really going to be mad about this." "Damn!" was the expression of Maria's idea "Leaving my cell phone at home was stupid." This technique is illustrated below.

JUDITH: What went through your mind when you heard about the family reunion?
ABE: "Uh-oh." I just thought, "Uh-oh."
JUDITH: Can you spell the thought out? "Uh-oh" means …
ABE: What if my ex-wife is there? She might be pretty unfriendly.

If clients are unable to spell out their thought, you might try supplying an opposite thought: "Did 'Uh-oh' mean, 'That's really good'?" It can be a good idea to supply the opposite thought, instead of your guess at the actual thought, because clients might agree with your hypothesized thought even if it's not exactly what went through their mind.

Automatic thoughts are sometimes expressed in the form of questions, which also aren't conducive to evaluation. When this happens, guide clients in expressing their thoughts in a statement form prior to helping them evaluate it.

JUDITH: So you thought, "What if I don't get the job?
ABE: Yes.
JUDITH: What are you concerned could happen if you don't get the job?
ABE: Probably no one will hire me.

JUDITH: Could we take a look at that thought? That if you don't get this job, probably no one will hire you?

Here are some examples of restating clients' automatic thoughts that were in the form of questions by asking what they were concerned about (or what they were most afraid could happen) if they encountered a difficult situation:

Question	***Statement***
"Will I be able to cope?"	"I won't be able to cope."
"Can I stand it if she leaves?"	"I won't be able to stand it if she leaves."
"What if I can't do it?"	"I'll lose my job if I can't do it."
"How will I get through it?"	"I won't be able to get through it."
"What if I can't change?"	"I'll be miserable forever if I can't change."
"Why did this happen to me?"	"This shouldn't have happened to me."

DIFFICULTIES IN ELICITING AUTOMATIC THOUGHTS

Sometimes clients just don't know the answer to "What's going through your mind?" You can use various techniques to help clients when they have difficulty (1) identifying their automatic thoughts from a past situation, (2) predicting their automatic thoughts in a future situation, or (3) or identifying thoughts that arise in the session itself. First, ask clients to describe the situation. Then try one or more of the following:

- Heighten the client's response.
- Have the client visualize the distressing situation.
- If the situation involves another person, suggest the client re-create it in a role play with you.
- Inquire about images.
- Supply thoughts you believe are probably *opposite* to the client's thoughts.
- Ask for the meaning of the situation.

These techniques are illustrated below.

Heightening Emotional and Physiological Responses

To help clients gain greater access to their thoughts, try to increase their emotional and physiological arousal.

JUDITH: Abe, when it's time to go to breakfast with your buddies on Sunday, what do you think will be going through your mind?
ABE: I'm not sure.
JUDITH: How do you think you'll be feeling?
ABE: Probably anxious.
JUDITH: Where will you feel the anxiety?
ABE: Here (*putting his hand on his abdomen*), in my stomach.
JUDITH: Can you feel the same feeling now?
ABE: (*Nods*.)
JUDITH: (*speaking in the present tense*) So you're at home, you're thinking about going out … You're feeling anxious; you can feel it in your stomach … What's going through your mind?
ABE: What if they don't really want to be there? What if they don't really want to see me?

Visualizing the Situation

Sometimes it helps when clients describe the situation in detail and then see it in their mind's eye.

JUDITH: Okay, you were at your son's house earlier this week and you began feeling really upset?
ABE: Yes.
JUDITH: What was going through your mind?
ABE: I don't know. I was just feeling really bad.
JUDITH: Can you describe the scene for me? What time was it? What were you doing?
ABE: It was about 6 o'clock. My son hadn't gotten home from work yet. My daughter-in-law was in the kitchen, and I was just sitting alone in the living room.

JUDITH: Where were your grandsons?
ABE: They were upstairs in their room.
JUDITH: So can you see the scene as if it's happening right now? You're in the living room. Are you sitting in a chair or on the couch? What's your posture like?
ABE: I'm on the couch, kind of slumped over.
JUDITH: Your son isn't home yet. Your daughter-in-law is in the kitchen—can you hear her moving around? You know your grandsons are upstairs, but you're sitting alone, all by yourself, and you're thinking …
ABE: [expressing his automatic thoughts] I used to have such a good life. Now *nothing* is good about it.

Re-Creating an Interpersonal Situation through Role Play

In this re-creation, clients initially describe who said what verbally; then they play themselves while you play the other person in the interaction.

JUDITH: So, you were feeling down as you were talking to talking to your neighbor?
ABE: Yes.
JUDITH: What was going through your mind as you were talking to him?
ABE: (*Pauses*.) … I don't know. I was just really down.
JUDITH: Can you tell me what you said to him and what he said to you?
ABE: (*Describes verbal exchange.*)
JUDITH: Can we try a role play? I'll be your neighbor, and you be you.
ABE: Okay.
JUDITH: While we're doing the role play, see if you can figure out what's going through your mind.
ABE: (*Nods.*)
JUDITH: Okay, you start. What do you say first?
ABE: Uh, can I ask you a question?
JUDITH: Sure.
ABE: I really need a job. Do you think you could ask your boss if he needs someone?

JUDITH: I'm not sure … Have you looked down at the mall? One of the stores might be hiring.
ABE: I'm not sure I want to work retail.
JUDITH: I wish I could help you, but … Okay, out of role play. Were you aware of what was going through your mind?
ABE: Yeah. I was thinking that he doesn't want to help me. He must think I'd do a bad job.

Inquiring about Images

If you become aware of an image in your own mind as the client is describing a situation, use it as a prompt to remind you to ask the client about experiencing an image: "Sometimes it's hard to identify your automatic thoughts. Let me ask you this: When you thought that you might see your ex-wife at your son's birthday party, did you have a picture in your mind of what she might look like?"

Suggesting an Opposite Thought

Interestingly, clients sometimes have greater access to their thoughts when you supply them with a thought that you believe is *opposite* to their actual thoughts.

ABE: I don't know what's likely to go through my mind as I get ready for the job interview. All I know is that I'll be really anxious.
JUDITH: [summarizing] I don't imagine you'll be thinking how *great* it will probably go?
ABE: No, not at all! I'll probably be thinking that I'm going to mess it up.

Eliciting the Meaning of the Situation

When clients have difficulty accessing their thoughts, you can ask them what the situation *meant* to them.

JUDITH: What did it mean to you that you didn't get the job?
ABE: That I'm just not good enough. I'll probably never get a job.

Be careful about using too many techniques when clients have difficulty figuring out their thoughts. Otherwise they may feel interrogated or view themselves as having failed. Downplay the importance of identifying *these* specific thoughts. "Well, sometimes these thoughts are hard to catch. No big deal. How about if we move on to _____?"

TEACHING CLIENTS TO IDENTIFY AUTOMATIC THOUGHTS

As described in Chapter 6, you can begin teaching clients the skill of identifying automatic thoughts even during the first session. Here I have just demonstrated the cognitive model, using Maria's examples.

JUDITH: Maria, when you notice your mood getting worse or you're doing something that's not helpful in the next week, could you stop and ask yourself, "What's going through my mind right now?"
MARIA: Yeah.
JUDITH: Maybe you could jot down a few of these thoughts on paper or in your phone?
MARIA: Okay.
JUDITH: Now don't worry if you have some trouble figuring out what you're thinking. It's a skill, and you'll get better at it over time.

In later sessions, you might also explicitly teach the client other techniques if the basic question ("What's going through your mind right now?") isn't effective. The handout in Figure 12.2 can be useful.

1. What's going through my mind? or What am I thinking?
2. What am I definitely NOT thinking? (Identifying an opposite thought can help prompt you to identify the actual thought.)
3. What does the situation *mean* to me?
4. Am I making a prediction? Or remembering something?

REMEMBER: JUST BECAUSE I THINK SOMETHING DOESN'T NECESSARILY MEAN IT'S TRUE.

FIGURE 12.2. Questions to Identify Automatic Thoughts handout. Copyright © 2018 Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

> "If you still have trouble figuring out what's going through your mind, this handout might help. (*Goes through the handout with the client.*) How about trying out some of these questions this week if you can't figure out what you're thinking?"

SUMMARY

Automatic thoughts coexist with a more manifest stream of thoughts, arise spontaneously, and are not based on reflection or deliberation. People are usually more aware of their associated emotion or behavior. With a little training, though, they can become aware of what's going through their minds. Automatic thoughts are associated with *specific* emotions, depending on their content and meaning. They are often brief and fleeting and may occur in verbal and/or imaginal form. People usually accept their automatic thoughts as true, without reflection or evaluation. Identifying, evaluating, and responding to automatic thoughts (in a more adaptive way) usually produces an adaptive shift in affect and/or behavior.

The next chapter clarifies the difference between automatic thoughts and emotions.

REFLECTION QUESTIONS

What are some ways you can help clients identify their automatic thoughts? How can you prevent clients from being self-critical if they have difficulty?

PRACTICE EXERCISE

Do a role play in which a client is struggling to identify his or her automatic thoughts.

13

EMOTIONS

Emotions are of primary importance in CBT. After all, a major objective of treatment is to help clients feel better by decreasing negative emotion and increasing positive emotion. Intense negative emotion is painful and may be dysfunctional if it interferes with a client's capacity to think clearly, solve problems, act effectively, or gain satisfaction—all of which can be obstacles to achieving their goals. Clients with a psychiatric disorder often experience an intensity of emotion that can seem excessive or inappropriate to the situation. Abe, for example, felt enormous guilt and then sadness when he forgot he was supposed to go to his daughter's house for dinner. He was also very anxious about calling the bank to straighten out an error. Yet the intensity and quality of Abe's emotions made sense when I recognized how strongly he believed his automatic thoughts and beliefs and how strongly he held certain values.

In addition, it's important to recognize the *positive* functions of negative emotion. Sadness can be a signal to fill what you perceive is missing in life. Guilt can motivate you to do what is truly important to you. Anxiety can give you energy to deal with a challenge. Anger can provide energy to do the right thing in the right way in the service of your values.

This chapter answers the following questions:

- How do you elicit and strengthen positive emotions?
- How do you help clients label their negative emotions?
- How do you guide clients to rate the intensity of their emotions?

How are automatic thoughts different from emotions?

How does the content of automatic thoughts match with emotion?

When is it advisable to increase negative emotion?

How can you identify and help clients test their beliefs about negative emotion?

What techniques are useful in regulating emotion?

ELICITING AND STRENGTHENING POSITIVE EMOTIONS

Positive emotions promote a sense of well-being (both psychologically and physically) and resilience, both of which are important during treatment and after treatment has ended. When clients have a negative emotion, they often narrow their attention and experience autonomic arousal. Positive emotions broaden their attention, cognitions, and behavioral tendencies and decrease their arousal (Fredrickson, 2001). Recalling positive memories of how they have coped with difficulties in the past allows clients to cope better in the present (Tugade et al., 2004).

You will actively work to elicit and increase clients' positive emotions in the session and throughout the week by

- discussing their interests, positive events that occurred during the week, and positive memories;
- creating Action Plans aimed at increasing positive emotions by, for example, becoming engaged in social, pleasurable, meaningful and productive activities and giving themselves credit; and
- helping clients draw adaptive conclusions about their experiences, for example, by asking:

  "What does this experience show you?"

  "What does it say about you that you [did _____]?"

  "How do you think _____ views you [as a result of this positive experience]?"

  "I think this [experience] points out _____ about you. Do you think I'm right?"

It's also helpful to have clients specify their positive emotions by asking:

> "How did you feel when you did _____ [or when _____ happened]?"
> "How did you feel afterward?"

Many clients have an impoverished vocabulary for positive emotions. Asking them to identify all the positive emotions they experienced in a situation can increase their ability to label these emotions and may also lift their mood, especially if you give them the list in Figure 13.1. If the list could be overwhelming to a client, whittle it down or provide them with a multiple choice: "When your friend finally called, did you feel glad? Relieved? Thankful?"; "When you watched your grandson score a goal, did you feel happy? Proud? Excited?" To increase the strength of their positive emotions in session, ask clients to imagine the situation as if it's happening now, and see if they can reexperience those emotions.

> Accepted, adventurous, affectionate, affirmed, agreeable, amazed, amused, appreciative, awesome, benevolent, blessed, bold, calm, capable, centered, cheerful, confident, content, creative, curious, delighted, dynamic, eager, elated, empowered, energized, enthusiastic, excited, fortunate, free, friendly, fulfilled, generous, grateful, happy, helpful, hopeful, in awe, in control, insightful, inspired, intelligent, interested, joyful, kindly, light, love, motivated, open, optimistic, passionate, peaceful, playful, pleasantly surprised, pleased, proud, reassured, relieved, resilient, respected, reverent, safe, satisfied, secure, serene, sincere, stimulated, supported, tender, thankful, thrilled, tranquil, understood, valuable, vibrant, virtuous, vital, wise, worthy, youthful, zany

FIGURE 13.1. List of positive emotions.

LABELING NEGATIVE EMOTIONS

When clients have difficulty identifying their negative emotions, you can offer them a short multiple choice ("Were you feeling happy, sad, anxious, angry …?") They can also refer to a list of negative emotions (Figure 13.2). If clients still have difficulty differentiating their negative emotions, you can help them create a chart (Figure 13.3). You'll ask

clients to list current or previous situations in which they felt a particular emotion.

- Sad, down, lonely, unhappy, depressed
- Anxious, worried, fearful, scared, tense, afraid, suspicious, tense, unsure, panicky
- Angry, mad, irritated, annoyed, frustrated, misunderstood, resentful, wronged
- Ashamed, embarrassed, humiliated
- Disappointed, discouraged, in despair
- Jealous, envious
- Guilty
- Hurt
- Suspicious

FIGURE 13.2. Partial list of negative emotions.

Directions: For each emotion below, fill in three situations in which you felt that emotion.

Angry	**Sad**	**Anxious**
Friend cancels plans with me	*Plans for evening fall through*	*Seeing how low my bank account is*
Neighbor doesn't return my suitcase	*Not enough money to go away on vacation*	*Hearing that there might be a hurricane*
Driver plays music too loudly	*Nothing to do all weekend*	*Finding a bump on my neck*

FIGURE 13.3. Sample emotion chart for Maria.

JUDITH: I'd like to spend a few minutes talking about different emotions so we can both understand better how you feel in different situations. Okay?

MARIA: Yeah.

JUDITH: Can you remember a time when you felt angry?

MARIA: Uh, yeah … When my friend cancelled plans to go to this concert; I forget which one, but I really wanted to go. Anyway, she told me she was going out with some other friends instead.

JUDITH: And what was going through your mind?

MARIA: Who does she think she is? I wouldn't do that to her. She should treat me better.
JUDITH: And you felt—
MARIA: Mad.

Here I had Maria recall a *specific* event in which she felt a given emotion. From her description, it sounded as if she had correctly identified her emotion. Because I wanted to make sure, I asked her to identify her automatic thoughts. The content of the automatic thoughts did match her stated emotion. Next, I asked Maria to fill out the chart with other situations when she recalled feeling angry, sad, and anxious. I asked her to refer to the chart in session and at home whenever she was having difficulty labeling how she was feeling.

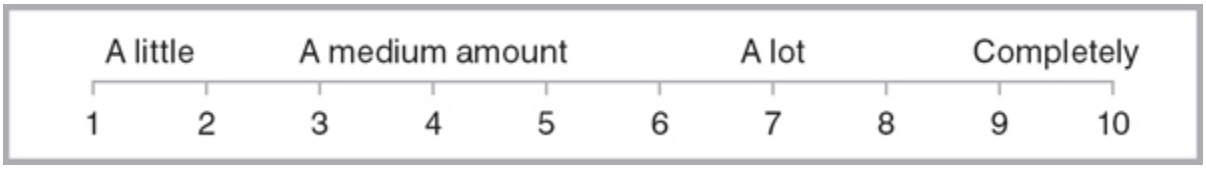
RATING THE INTENSITY OF EMOTION

At times, you'll ask clients to not only *identify* their emotion but also *quantify* the degree of emotion they're experiencing. For example, rating how strongly a client feels a certain emotion before and after a therapeutic intervention helps you decide whether to use additional interventions, so you can avoid prematurely moving on to another cognition or issue. Or the opposite can happen—you may continue discussing a cognition or issue, not realizing that the client is no longer significantly distressed by it. Finally, gauging the intensity of an emotion in a particular situation helps you and the client determine whether it warrants closer scrutiny in the first place. A situation that is relatively less emotionally laden may be less valuable to discuss than one that is more distressing to the client, where important beliefs may have been activated. Most clients learn to judge the intensity of an emotion fairly easily.

JUDITH: How did you feel when your friend said, "Sorry, I don't have time now"?
MARIA: Pretty sad, I guess.
JUDITH: If 10 is the saddest you ever felt and 0 is not sad at all, how sad did you feel right when he said, "Sorry, I don't have time now"?

MARIA: About 7 or 8.

Some clients have difficulty with or don't like putting a specific number to the intensity of emotion. You can ask them to rate whether they experienced the emotion "mildly," "moderately," or "intensely." If even that is difficult, drawing a scale can help.



JUDITH: How did you feel when your sister told you she wasn't coming to visit after all?
MARIA: Sad.
JUDITH: How sad did you feel, 0 to 10?
MARIA: I'm not sure. I'm not too good with numbers.
JUDITH: Do you think you felt a little sad? Moderately sad? Intensely sad?
MARIA: What were the choices again?
JUDITH: Here, let me draw a scale. Your sadness—would you say (*pointing to the scale*) that you were a just a little, a medium amount, very sad, or completely sad?
MARIA: Oh, very sad; I guess an 8.
JUDITH: Okay, we've got our scale now. Let's see how useful it is. Were you sad any other times this week?
MARIA: Yeah, last night when Tanisha didn't call me back.
JUDITH: Can you use this scale as a guide? About how sad did you feel?
MARIA: A medium amount—maybe 6.
JUDITH: Good. Now, do you think you could use this scale when you're trying to figure out how distressed you are?
MARIA: Yeah, I can do that.

DIFFERENTIATING AUTOMATIC THOUGHTS FROM EMOTIONS

It's important for clients to recognize (and label) their negative emotions, especially when they pose an obstacle to taking steps to fulfill their goals. We don't want to *eliminate* negative emotion. Negative emotions are as much a part of the richness of life as positive emotions and serve as important a function as does physical pain, often alerting us to potential problems we may need to address.

But we do want to decrease *excessive* negative emotion. We don't evaluate, challenge, or dispute clients' emotions. Rather we acknowledge, empathize, and validate clients' emotions and then collaboratively decide whether to evaluate the *cognitions* that led to their distress—or intervene in another way, such as problem solving, turning attention to something else, accepting the negative emotion, or using other emotion regulation techniques.

You won't discuss *all* situations in which clients feel dysphoric—but you will use your conceptualization of the client to collaboratively decide which situations are most important to address, which goals to work toward and what obstacles could get in the way. Often the greatest obstacles are associated with high levels of distress or dysfunction.

At the beginning of treatment, many clients don't clearly understand the difference between their thoughts and their emotions. You continually and subtly help clients view their experiences through the cognitive model. When clients describe an issue or obstacle, ask questions to organize the material into the categories of the cognitive model: situation, automatic thought, and reaction (emotion, behavior, and physiological response).

One reason that clients confuse thoughts and emotions is that they sometimes use the word "feel" to indicate an emotion ("I feel anxious"). At other times, they use the word "feel" when they report a cognition ("I feel like I can't do it"; "I feel like a failure"; or "I feel worthless"). At these times, based on the flow of the session, their goals, and the strength of the collaboration, you may decide to

- ignore the confusion,
- address it at the time (either subtly or explicitly), or
- address it later.

Most of the time, mislabeling a thought as a feeling is relatively unimportant in a given context, and you can make a subtle correction.

JUDITH: You mentioned when we set the agenda that you wanted to talk about the phone call you had with your brother?
ABE: Yeah. I called him a couple of nights ago and he sounded kind of distant.
JUDITH: When he sounded distant, how did you feel?
ABE: I felt like he really didn't want to talk, like he didn't really care whether I had called or not.
JUDITH: So when you had the thoughts "He doesn't really want to talk. He doesn't really care that I called," how did you feel emotionally? Sad? Angry? Anxious? Something else?

In another session, I viewed the confusion as important because I wanted to teach Abe how to evaluate his thinking, using a Thought Record (pp. 267–268). I deliberately decided to distinguish thoughts from emotions. I didn't want him to think that I was questioning what he had viewed as an emotion. I also judged that the interruption wouldn't unduly affect the flow of the session and that we wouldn't forget important data.

JUDITH: Were there any times this week when you thought about going to the movies?
ABE: Yeah, a few times.
JUDITH: Can you remember one time specifically?
ABE: Yesterday after lunch, I was cleaning up … I don't know.
JUDITH: How were you feeling emotionally?
ABE: [expressing thoughts] Oh, I was feeling like it's no use, that seeing a movie probably wouldn't help.
JUDITH: Those are important thoughts. We'll get back to evaluating them in a minute, but first I'd like to review the difference between thoughts and feelings. Okay?

ABE: Sure.
JUDITH: Feelings are what you feel *emotionally*—usually they're one word, such as sadness, anger, anxiety, and so on. (*pause*) Thoughts are *ideas* that you have; you think them either in words or in pictures or images, like "It's no use. It probably won't help." (*pause*) Do you see what I mean?
ABE: I think so.
JUDITH: So let's get back to yesterday when you thought about going out for a walk. What emotion were you feeling?
ABE: Sad, I think.
JUDITH: And your thoughts were "This is no use. I'll never get better"?
ABE: Yes.

In the example above, Abe initially labeled thoughts as feelings. At times, clients do the reverse: that is, they label an emotion as a thought.

JUDITH: As you walked into your empty apartment, Maria, what went through your mind?
MARIA: I was sad, lonely, real down.
JUDITH: So you felt sad and lonely and down. What thought or image made you feel that way?

MATCHING THE CONTENT OF AUTOMATIC THOUGHTS TO EMOTIONS

You continuously conceptualize clients' problems and the obstacles that interfere with goal attainment. You try to understand their experience and point of view and how their underlying beliefs give rise to specific automatic thoughts in a specific situation, influencing their emotions and behavior. The connection among clients' thoughts, emotion, and behavior should make sense. You will investigate further when clients report an emotion *that doesn't seem to match* the content of their automatic thoughts.

JUDITH: How did you feel when you realized you hadn't heard back from your old boss?
ABE: I was sad.
JUDITH: What was going through your mind?
ABE: I was thinking, "What if he doesn't want to give me a good recommendation? What if I don't get the job?"
JUDITH: And you felt sad?
ABE: Yes.
JUDITH: I'm a little confused because those sound more like anxious thoughts. Was there anything else going through your mind?
ABE: I'm not sure.
JUDITH: How about if we have you imagine the scene? [helping Abe vividly recall the scene in imagery form] You said you were home, looking online for job possibilities. Can you see yourself? Where are you?
ABE: At my desk.
JUDITH: And you're thinking, "What if he doesn't give me a good recommendation? What if I don't get the job?" And you're feeling …?
ABE: Nervous, I guess.
JUDITH: What else is going through your mind?
ABE: I think I was remembering when my boss told me I was being laid off. I was feeling like such a failure.
JUDITH: And how were you feeling emotionally?
ABE: Sad. Real sad.

This interchange started with a discrepancy. I was alert and so was able to pick up an inconsistency between the *content* of Abe's automatic thought and the *emotion* associated with it. I was then able to help Abe retrieve an important image (a memory) and a key automatic thought by using imaginal recall. Had I chosen to focus on the anxious thoughts, I may have missed an important cognition.

INCREASING NEGATIVE EMOTION

Some techniques are actually designed to heighten negative affect. This is important when clients need

- to gain greater access to their thoughts;
- to change their cognitions at the emotional level;
- to learn that emotions aren't dangerous, uncontrollable, or intolerable; and/or
- to examine the disadvantages or consequences of some of their maladaptive behavior.

You can use imagery, exposure, or focusing on somatic sensations to increase the intensity of clients' negative emotion.

TESTING BELIEFS ABOUT NEGATIVE EMOTIONS

Some clients have dysfunctional beliefs about experiencing emotion (Greenberg, 2002; Hofmann, 2016; Linehan, 2015), as illustrated with Maria, below.

MARIA: I didn't end up calling my mother this weekend.
JUDITH: What [obstacle] got in the way?
MARIA: I don't know. I guess I got nervous.
JUDITH: Did you make a prediction about what would happen if you called?
MARIA: I just thought I might get really upset.
JUDITH: And then what could happen?
MARIA: I was afraid I just couldn't stand it. If she got me upset, I might start crying and never stop.

Like Maria, some clients believe that negative emotions are unsafe: "If I get upset, _____," for example, "it will get worse and worse until I can't stand it, I'll lose control, it will never go away, or I'll end up in the hospital." These kinds of beliefs can interfere with working to achieve their goals. Clients may avoid situations in which they predict they will become upset. They may avoid talking about or even thinking about

distressing problems. When clients have dysfunctional cognitions about experiencing negative emotion, they may not make much progress in treatment. You can use standard cognitive restructuring techniques to help clients evaluate their beliefs. Doing a behavioral experiment using mindfulness (pp. 278–279) is especially effective. When clients successfully disengage from a thought process such as worry, you can guide them in changing their cognitions from "Worry is uncontrollable" to "I can choose to disengage in worry when I notice it has started."

TECHNIQUES TO REGULATE EMOTION

Throughout this book, you'll learn techniques to help clients regulate their emotions. For example:

- Problem solving
- Evaluating and responding to negative thoughts
- Engaging in (and being fully mindful of) social, pleasurable, or productive activities
- Exercising
- Accepting negative emotion nonjudgmentally
- Using mindfulness (to detach from upsetting thoughts)
- Doing relaxation, guided imagery, or breathing exercises
- Engaging in self-soothing activities (walking in nature, taking a bath, hugging another person or a pet, listening to soothing music)
- Focusing on one's strengths and positive qualities, and giving oneself credit

See Linehan (2015) for an extensive description of emotion regulation and distress tolerance techniques. For more techniques and helpful metaphors to help clients accept negative emotion, see Hayes and colleagues (1999).

SUMMARY

Emotional reactions always make sense, given what the individual is thinking. You will seek to promote positive emotions in and outside of sessions. When clients express significant negative emotion, you'll conceptualize according to the cognitive model and you'll often address the associated cognitions. Some clients need to modify dysfunctional beliefs about experiencing negative emotion itself. It's important for clients to differentiate between their thoughts and their emotions and among different emotions. We empathize with clients' emotions, and we don't evaluate them. When needed, we help them to accept their negative emotions nonjudgmentally. A number of techniques help clients regulate their negative emotions and, when needed, develop greater tolerance of them.

REFLECTION QUESTION

What role do emotions play in CBT treatment?

PRACTICE EXERCISE

Do a role play in which you elicit a client's dysfunctional belief about experiencing negative emotion. Also help the same client experience positive emotion in the session.

14

EVALUATING AUTOMATIC THOUGHTS

Clients have hundreds or thousands of thoughts a day, some dysfunctional, some not, some relevant to treatment, others not. Part of the art of therapy is to conceptualize which thoughts are most important to address and how to address them. In this chapter, you'll learn the answers to the following questions:

- What kinds of thoughts do you address in treatment?
- How do you select the most important thoughts to work on?
- How do you use Socratic questioning to evaluate thoughts?
- How do you assess the outcome of the evaluation process?
- How do you conceptualize why evaluation might be ineffective?
- What are alternate methods of addressing thoughts?
- What do you do when thoughts are true?

TYPES OF AUTOMATIC THOUGHTS

Three kinds of thoughts are relevant to therapy:

1. Inaccurate thoughts that lead to distress and/or maladaptive behavior (especially those that present obstacles to achieving goals). You'll often evaluate them verbally or test through behavioral experiments.
2. Accurate but unhelpful thoughts. You might problem-solve, evaluate an inaccurate conclusion stemming from the thought, and/or work toward acceptance of an insoluble problem and changing the focus of attention.
3. Thoughts that are part of a dysfunctional thought process such as rumination, obsession, or self-criticism. You'll often evaluate beliefs about the thought process, use mindfulness techniques, and emphasize valued action.

Later in this chapter, you'll learn a variety of other techniques to address these three types of thoughts.

SELECTING KEY AUTOMATIC THOUGHTS

You have identified an automatic thought. Clients may have

- made a spontaneous utterance during a session (e.g., "I just don't think anything can help me");
- related an automatic thought, often from the past week; or
- made a prediction of an unhelpful thought they might have in the future.

Next you need to conceptualize whether this is an important thought on which to focus; that is, is it currently significantly distressing or unhelpful and likely to recur? Does it pose an obstacle to a goal? If it was an automatic thought from the past week, you might ask:

"In what situation did you have this thought [if the client reported a thought and not the situation]?"
"How much did you believe it at the time? How much do you believe it now?" [Clients can use a 0–10 or 0–100 scale, or words such as "a little," "a medium/moderate amount," "a lot," and "completely."]
"How did this thought make you feel emotionally? How intense was the emotion then? How intense is the emotion now?"
"What did you do?"

You will also ask yourself whether the client is likely to have this kind of thought again and be distressed by it. If not, it may not be an important enough cognition to spend time on.

Why do clients bring up problems and automatic thoughts that aren't important? Most of the time, it's because they aren't socialized well enough to treatment. Or sometimes they bring up problems that occurred just before the therapy session.

You will vary your questions slightly if clients spontaneously utter the thought and/or if they are predicting a thought they're likely to have later. You should also find out whether additional thoughts were more central or distressing:

> "What else went through your mind [in this situation]? Did you have any other thoughts or images?"
> "Did you feel any other emotion?" [If so,] "What thoughts/images went along with it?"
> "Which thought/image was most upsetting?"

Even if clients report an important automatic thought, you might collaboratively decide not to focus on it, especially if

- it might impair the therapeutic relationship (e.g., you perceive that clients are feeling invalidated),
- their level of distress is too high to evaluate their thinking,
- there's insufficient time in the session to help them respond effectively to the thought,
- it seems more important to work on another element of the cognitive model (e.g., you might focus instead on solving the problem, teaching the client emotion regulation techniques, discussing more adaptive behavioral responses, or addressing the client's physiological response),
- you decide you should work on a dysfunctional belief underlying the automatic thought, or
- you believe it's more important to discuss something else altogether.

QUESTIONING TO EVALUATE AN AUTOMATIC THOUGHT

Having elicited an automatic thought, determined that it is important and distressing, and identified its accompanying reactions (emotional, physiological, and behavioral), you may collaboratively decide with the client to evaluate it. *You will not directly challenge the automatic thought*, however, for several reasons:

- You usually don't know in advance the degree to which any given automatic thought is distorted (e.g., Abe's thought that he was going to run out of money could be valid).
- A direct challenge can lead clients to feel invalidated (e.g., Maria might think, "[My therapist] is telling me I'm wrong").
- Challenging a cognition violates a fundamental principal of CBT, that of collaborative empiricism: You and the client together examine the automatic thought, test its validity and/or utility, and develop a more adaptive response.

It's also important to keep in mind that automatic thoughts are rarely completely erroneous. Usually, they contain at least a grain of truth (which is important to acknowledge).

Instead of challenging or disputing automatic thoughts, we often use a gentle process of Socratic questioning. Initially, you may need to have a summary sheet of questions in front of you (Figure 14.1 or 14.2), a copy of which you can give to the client. (These questions are derived from worksheets, which you'll read about in the next chapter.) Eventually, you'll learn the questions so well that you won't need it. At that point, done well, this style of inquiry sounds almost conversational. Research shows that the Socratic method is generally superior to didactic methods. (Actually, "Socratic" is usually a misnomer; the Socratic questioning method, derived from the philosopher Socrates, involves a dialectical discussion.) Properly done, Socratic questioning leads to symptom change (Braun et al., 2015). Clients prefer this method; they find it more helpful and respectful and are more likely to engage in cognitive restructuring (Heiniger et al., 2018). See Overholser (2018) for an extensive discussion of the Socratic method of psychotherapy.

What is the evidence that the automatic thought is true? Not true?

Is there an alternative explanation?

What's the worst that could happen, and how could I cope? What's the best that could happen? What's the most realistic outcome?

What's the effect of my believing the automatic thought? What could be the effect of changing my thinking?

If _____ [friend's name] was in the situation and had this thought, what would I tell him/her?

What should I do about it?

FIGURE 14.1. Questions to evaluate automatic thoughts 1 (from the Thought Record).

What is the situation?

What am I thinking or imagining?

What makes me think the thought is true?

What makes me think the thought is not true or not completely true?

What's another way to look at this?

What's the worst that could happen? What could I do then?

What's the best that could happen?

What will probably happen?

What will happen if I keep telling myself the same thought?

What could happen if I changed my thinking?

What would I tell my friend [think of a specific person] if this happened to them?

What should I do now?

FIGURE 14.2. Questions to evaluate automatic thoughts 2 (from the Testing Your Thoughts Worksheet).

On the other hand, behavioral methods (if you help clients draw adaptive conclusions from their experiences) can be more powerful than Socratic questioning. Behavioral experiments are appropriate for almost every client (and are necessary for some, including young children and individuals with serious mental illness, brain injury, intellectual disabilities, or autism).

You may use questioning from the very first session to evaluate a specific automatic thought. In a subsequent session, you will begin to explain the process more explicitly, so clients can learn to evaluate their thinking between sessions:

JUDITH: (*Summarizes past portion of the session; writes automatic thoughts on paper for both to see.*) So when you considered calling Charlie, you thought, "He probably won't want to hear from me," and that thought made you feel sad?
ABE: Yeah.
JUDITH: And how much did you believe that thought at the time?
ABE: Oh, pretty much. About 90%.
JUDITH: And how sad did you feel?
ABE: Maybe 80%.
JUDITH: Do you remember what we've been talking about? Sometimes automatic thoughts like these are true, sometimes they turn out not to be true, and sometimes they have a grain of truth. Can we look at this thought about Charlie to see how accurate it seems?
ABE: Okay.
JUDITH: I'd like to show you a list of questions that might be helpful.

It's useful for clients to use one of the lists (Figure 14.1 or 14.2) to evaluate their thoughts verbally with you in session. If they're successful, you can suggest that they use the list between sessions as part of their Action Plan when they identify an automatic thought. They can then think about their responses or write them down. But make sure it's appropriate to give them the list. Some clients become overwhelmed by the number of questions. When you predict this is the case, teach them just one or two questions, which you or the client can record. Or circle a few questions on one of the lists. But before suggesting that they use these questions at home, make sure that

- they understand that evaluating their thinking can help them feel better,
- they believe they will be able to use the questions effectively, and
- they understand that not all questions apply to all automatic thoughts.

You should also guide them so they'll know when and how to use the questions.

JUDITH: Abe, it would be too burdensome for you to use these questions for *every* automatic thought you have this week. So, when you notice your

mood getting worse or you're doing something that isn't helpful, try to catch your automatic thoughts, and then think to yourself, "Do I have therapy notes that cover this?" Okay?

ABE: Yes.

JUDITH: If this is a *new* thought, you'll definitely want to pull out the list at least some of the time. Now, ideally, you'd not only ask yourself the questions but also *write down* your answers, if you can. How does that sound?

ABE: Fine.

CLINICAL TIPS

The evaluation of client's thoughts should be evenhanded. We don't want clients to ignore evidence that supports an automatic thought, devise an unlikely alternative explanation, or adopt an unrealistically positive view of what might happen. Let clients know that not all of the questions in the lists are relevant to every automatic thought. And using all of the questions, even if they logically apply, may be too cumbersome and time consuming. Clients may not evaluate their thoughts at all if they consider the process too burdensome.

You can use any set of questions to help clients evaluate their thinking, but the lists can be helpful as they guide you and the client to

- examine the validity of the automatic thought,
- explore the possibility of other interpretations or viewpoints,
- decatastrophize the problem situation,
- recognize the impact of believing the automatic thought,
- gain distance from the thought, and
- take steps to solve the problem.

Each question is described below.

"Evidence" Questions

Because automatic thoughts usually contain a grain of truth, clients usually do have some evidence that supports their accuracy (which you will help them identify first), but they often fail to recognize evidence to the contrary (which you will help them identify next):

JUDITH: What makes you think that Charlie won't want to hear from you? [or "What is the evidence that _____?"]
ABE: Well, it's been at least a month since I talked to him.
JUDITH: Anything else?
ABE: Well, the last time we got together, I wasn't much fun.
JUDITH: Anything else?
ABE: (*Thinks*.) No. I guess not.
JUDITH: Okay, now what makes you think it might not be true or not completely true [or "What's the evidence on the other side?"] that maybe he *would* want to hear from you?
ABE: I don't know. We used to be good friends. But I haven't seen him as much in the past few months.
JUDITH: Anything else?
ABE: When I cancelled plans with him last month, he sounded disappointed.
JUDITH: What did he say?
ABE: That he was sorry I wasn't feeling well. That he hoped I'd feel better soon.
JUDITH: Okay. [summarizing] So, on the one hand, you haven't heard from Charlie in over a month and you haven't seen him as often recently. You also think that last time you did get together, you weren't much fun. On the other hand, you've been friends for a long time, he seemed disappointed not to get together with you, and he seemed sympathetic. Is that right?
ABE: Yeah.

"Alternative Explanation" Questions

Next, I help Abe *devise a reasonable alternative explanation* for what has happened.

JUDITH: Good. Now, let's look at the situation again. Is there another way to look at this? [or "Could there be an alternative explanation for why you haven't heard from him in a month—other than he doesn't want to hear from you?"]
ABE: I don't know.
JUDITH: Why else might he have been out of touch?

ABE: I'm not sure. Sometimes he gets in a real crunch at work. Sometimes his wife wants him to stay home all weekend. I guess it's possible he's been too busy.

"Decatastrophizing" Questions

Many clients predict a worst-case scenario. Ask them how they could cope if the worst does happen.

JUDITH: Okay. Now, if the worst happens and it turns out he doesn't want to hear from you, what could you do? [or "How could you cope with that?"]
ABE: Well, I wouldn't be happy about it.
JUDITH: [asking leading questions to help him develop a robust response] Do you have other friends you could be in contact with?
ABE: It's been a while. But I suppose I could.
JUDITH: And you still have your children and grandchildren?
ABE: Yes.
JUDITH: So, would you be okay?
ABE: Yeah, I guess I would.

Clients' worst fears are often unrealistic. Your objective is to help them think of more realistic outcomes, but many clients have difficulty doing so. You might help them broaden their thinking by next asking for the *best* outcome.

JUDITH: Now the worst may be unlikely to happen. What's the *best* that could happen?
ABE: That I'll call him and he'll want to get together.
JUDITH: I wonder whether the best would be that *he'd* call *you* today and apologize for being out of touch and make plans to see you right away.
ABE: I guess that would be the best.
JUDITH: And what do you think will probably happen? [or "What is the *most realistic outcome*?"]
ABE: It's possible that he's only a little annoyed with me or that he's been busy and maybe he will want to get together.

CLINICAL TIPS

When clients' worst fears are that they'll die, you obviously won't ask the "How would you cope?" question. Instead, you might ask for the best and most realistic outcomes. You might also decide to ask what the worst part of dying would be: fears of the process of dying, fears of what they imagine an afterlife might be like, or fears of what would happen to loved ones after the client's death.

"Impact of the Automatic Thought" Questions

Below, I help Abe *assess the consequences of responding and not responding* to his distorted thinking.

JUDITH: And what will happen if you keep telling yourself that Charlie doesn't want to hear from you? [Or "What is the *effect of your thinking* that he doesn't want to hear from you?"]
ABE: It makes me sad. And I end up not calling him.
JUDITH: And what could happen if you changed your thinking? [or "What could be the *effect of changing your thinking*?"]
ABE: I'd feel better. I'd be more likely to call.

"Distancing" Questions

Clients often benefit from getting some distance from their thoughts by imagining what they would tell a close friend or family member in a similar situation.

JUDITH: Abe, let's say your son had a friend whom he was out of touch with for a month. If he thought, "My friend doesn't want to hear from me," what would you tell him?
ABE: I guess I'd tell him that a month isn't too long a time. That there may be a good reason they were out of touch. That it's worth it to contact his friend.
JUDITH: Does that apply to you?
ABE: Yes, I guess it does.

"Problem-Solving" Questions

The answer to "What would be good to do now?" may be cognitive and/or behavioral in nature. Sometimes clients should remind themselves of

something you've just discussed—for example: "I guess if I think _____, I need to remember _____." Abe said, "I guess if I think he doesn't want to hear from me, I need to remember that I'm probably wrong. He's probably just been busy." Abe and I also come up with a behavioral plan.

JUDITH: And what would you like to *do* about this situation?
ABE: Uh … I guess I should just go ahead and text him.

I would then ask how likely Abe was to text him and respond to obstacles that could get in the way. If I were unsure of Abe's social skills, I might have asked him, "What do you think you should say in the text?" If Abe thought it would be helpful, we might role-play what to say to his friend when they got together. We might evaluate the pros and cons of his disclosing his depression. We might brainstorm things to talk about to lighten the mood. I might ask Abe if he wants to text Charlie right then in my office.

ASSESSING THE OUTCOME OF THE EVALUATION PROCESS

In the last part of this discussion, I assess how much Abe now believes the original automatic thought and how he feels emotionally, so I can decide what to do next in the session.

JUDITH: Good. Now, how much do you believe this thought: "Charlie doesn't want to hear from me"?
ABE: Not that much. Maybe 30%.
JUDITH: Okay. And how sad do you feel?
ABE: Not much either.
JUDITH: Good. It sounds like this exercise was useful. Let's go back and see what we did that helped.

You and the client won't use all the questions in the lists for every automatic thought you evaluate. Sometimes none of the questions seems

useful, and you might go in a different direction altogether. Also, don't expect that clients' belief in the automatic thought to go down to 0% or that their negative mood will go away completely.

CONCEPTUALIZING WHEN COGNITIVE RESTRUCTURING IS INEFFECTIVE

When mood and/or behavior don't improve, you need to conceptualize why this initial attempt at cognitive restructuring hasn't been sufficiently effective. Common reasons to consider include the following:

1. There are more central automatic thoughts and/or images you haven't yet identified or evaluated.
2. The evaluation of the automatic thought is implausible, superficial, or inadequate.
3. The client hasn't sufficiently expressed the evidence that seems to support the automatic thought.
4. The automatic thought itself is also a broad, overgeneralized cognition: a core belief (such as "I'm helpless/I'm unlovable/I'm worthless").
5. The client understands intellectually that the automatic thought is distorted but not on an emotional level.
6. The automatic thought is part of a dysfunctional thought pattern.

My supervisee, Andrew, was a novice therapist. He made some mistakes when he was treating Margaret, a woman with social anxiety. In the first situation, *the client didn't verbalize the most central automatic thought or image*. Margaret had several automatic thoughts but verbalized only one. When Andrew helped her evaluate this automatic thought, she experienced only a mild decrease in the intensity of her anxiety. He should have questioned her more carefully before jumping in to evaluate the first thought she expressed.

In a second situation, *the client responded to an automatic thought superficially*. Margaret thought, "My coworker might criticize me." Instead of carefully evaluating the thought, she merely responded, "He probably won't." This response was insufficient, and her anxiety didn't decrease.

In a third situation, *the therapist didn't thoroughly probe for, and therefore the client didn't fully express, the evidence that the automatic thought was true*, resulting in an ineffective adaptive response, as seen here:

THERAPIST: Okay, Margaret, what evidence do you have that your friend doesn't want to bother with you?
MARGARET: Well, she hardly ever calls me. I always call her.
THERAPIST: Okay, anything on the other side? That she does care about you, that she does want a good relationship with you?

Had Andrew asked her additional questions, he would have uncovered other evidence that Margaret has to support her automatic thought: that her friend has turned down several invitations to spend time with her, that she sounded impatient on the phone the last few times when she called, and that she had not sent Margaret a birthday card. Having elicited this additional data, Andrew could have helped Margaret weigh the evidence more effectively.

In a fourth situation, *the client identified an automatic thought that was also a core belief*. Margaret often thinks, "There's something wrong with me." She believes this idea so strongly that a single evaluation doesn't alter her perception or the associated affect. In an early session, she lists many situations in which she feels anxious and then she reports this cognition to Andrew. Andrew starts helping her evaluate it. But he should have focused on a *specific* situation in which she had this thought—for example: "Can we talk about the party you went to over the weekend when no one came up to you and you thought, 'There's something wrong with me'? Could there have been another reason that no one came up to you?" Andrew will need to use many techniques over time to alter the client's overgeneralized core belief (see Chapter 18).

In a fifth situation, *the client indicated that she believes an adaptive response "intellectually," in her mind, but not "emotionally," in her heart, soul, or gut*. She discounts the adaptive response. In this case, Andrew and Margaret should have explored an unarticulated belief that lay *behind* the automatic thought:

THERAPIST: How much do you believe that Christina probably has other reasons for not putting you on her work team?
MARGARET: Well, I can see it intellectually.
THERAPIST: But?
MARGARET: I still think if she really liked me, she would have included me.
THERAPIST: So what does it mean that she didn't include you?
MARGARET: It means I'm not good enough.

Here, Andrew discovers that Margaret doesn't really believe the adaptive response because of her belief "If people don't include me in something, it means I'm not good enough."

To summarize, having evaluated an automatic thought, ask clients to rate how much they believe the adaptive response and how they feel emotionally. If their belief is low and they are still distressed, conceptualize why examining the thought didn't alleviate their distress, and plan a strategy for what to do next.

ALTERNATE METHODS TO ADDRESS AUTOMATIC THOUGHTS

There are many other techniques to help clients assess their thinking (Dobson & Dobson, 2018; Leahy, 2018; Tolin, 2016). To name just a few, you can

- vary your questions,
- identify the cognitive distortion,
- design a behavioral experiment,
- use self-disclosure, and/or
- ask clients to compose a helpful response.

These strategies are described below.

Using Alternative Questions

When you predict that standard questions won't be effective enough, vary your line of questioning.

JUDITH: [summarizing] So you called your ex-wife to try to get her to sign the papers. What went through your mind when she got angry?
ABE: I should have known she'd get angry. I should have waited to call her.
JUDITH: What makes you think you shouldn't have called?
ABE: Well, she's usually in a bad mood on Sunday nights.
JUDITH: Had that occurred to you?
ABE: Well, yeah, but I wanted to let my daughter know right away if she could count on us to help her out with her car loan. She really needed to know.
JUDITH: So you actually had a reason for calling when you did, and it sounds as if you knew it might be risky, but you really wanted to let Kaitlyn know as soon as you could?
ABE: Yeah.
JUDITH: Is it reasonable to be so hard on yourself for taking the risk?
ABE: No …
JUDITH: You don't sound convinced. How bad is it anyway, in the scheme of things, for your ex-wife to be mad at you?

I followed up these questions with others: "How reasonable was it for you to bring this up with your ex-wife? How reasonable was it for her to get angry? How does she probably feel now? Is it possible for you to always avoid getting her angry? Can you possibly do what is good for you and your children and grandchildren without getting her angry?"

These nonstandard questions helped Abe adopt a more functional perspective. Although I started out questioning the *validity* of the thought, I shifted the emphasis to the *implicit underlying belief* (which we had previously discussed in other contexts): "I should be able to avoid having others get upset with me." At the end, I asked Abe an open-ended question ("How do you see the situation now?") to see whether he needed more help in responding to his thoughts. Note that many questions I asked were a variation of the Socratic question "Is there an alternative explanation [for why you called when you did and for why your ex-wife was angry, other than that you were at fault]?"

Identifying Cognitive Distortions

Clients tend to make consistent errors in their thinking. Often there is a systematic negative bias in the cognitive processing of clients who suffer from a psychiatric disorder (Beck, 1976). The most common errors are presented in Figure 14.3 (see also Burns, 1980). It sometimes helps to label distortions and to teach clients to do the same. Be sure to tell them that the categories overlap and they may find that some automatic thoughts contain more than one distortion. Before providing the client with a list, you might start by making mental notes of his or her most common distortions and then point out a specific distortion when you spot a pattern:

> "Abe, this idea that either you're a total success or you're a failure—that's what we call all-or-nothing thinking. Does it seem familiar? I remember you also had the idea that because you hadn't been able to do all your new job responsibilities at work it meant you had completely failed. And that if you're not doing everything you can for your grandchildren, then you're a failure as a grandfather. Do you think it could be helpful to watch out for this kind of thinking?"

All-or-nothing thinking	Also called black-and-white, polarized, or dichotomous thinking. You view a situation in only two categories instead of on a continuum.	*Example*: "If I'm not a total success, I'm a failure."
Catastrophizing (fortune-telling)	Also called fortune-telling. You predict the future negatively without considering other, more likely outcomes.	*Example*: "I'll be so upset, I won't be able to function at all."
Disqualifying or discounting the positive	You unreasonably tell yourself that positive experiences, deeds, or qualities do not count.	*Example*: "I did that project well, but that doesn't mean I'm competent; I just got lucky."
Emotional reasoning	You think something must be true because you "feel" (actually believe) it so strongly, ignoring or discounting evidence to the contrary.	*Example*: "I know I do a lot of things okay at work, but I still feel like I'm a failure."

Labeling	You put a fixed, global label on yourself or others without considering that the evidence might more reasonably lead to a less extreme conclusion.	*Examples*: "I'm a loser"; "He's no good."
Magnification/minimization	When you evaluate yourself, another person, or a situation, you unreasonably magnify the negative and/or minimize the positive.	*Example*: "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm smart."
Mental filter	Also called selective abstraction. You pay undue attention to one negative detail instead of seeing the whole picture.	*Example*: "Because I got one low rating on my evaluation [which also contained several high ratings], it means I'm doing a lousy job."
Mind reading	You believe you know what others are thinking, failing to consider other, more likely possibilities.	*Example*: "He's thinking that I don't know the first thing about this project."
Overgeneralization	You make a sweeping negative conclusion that goes far beyond the current situation.	*Example*: "Because I felt uncomfortable at the meeting, I don't have what it takes to make friends."
Personalization	You believe others are behaving negatively because of you, without considering more plausible explanations for their behavior.	*Example*: "The repairman was curt to me because I did something wrong."
"Should" and "must" statements	Also called imperatives. You have a precise, fixed idea of how you or others should behave, and you overestimate how bad it is that these expectations are not met.	*Example*: "It's terrible that I made a mistake. I should always do my best."
Tunnel vision	You only see the negative aspects of a situation.	*Example*: "My son's teacher can't do anything right. He's critical and insensitive and lousy at teaching."

FIGURE 14.3. Thinking errors. Adapted with permission from Aaron T. Beck.

Identifying distortions can help clients gain distance from their thoughts. But as with all techniques, make sure it's helpful to clients, they understand the rationale, and they don't feel overwhelmed by the list. I see it as a helpful strategy for many clients, but it's not essential. It's especially important to review the list in session so you can make sure clients understand how to use it before you ask them to label their distortions as part of their Action Plan.

At our next session, I gave Abe the list, and together we identified his typical automatic thougvhts and the distortions they represented. For example:

Catastrophizing: "I'll never get another job."
All-or-nothing thinking: "Since my apartment is messy, it means it's completely out of control."
Mind reading: "My friend doesn't want to be around me."
Emotional reasoning: "I feel like such a failure; I must *be* a failure."

I circled these four distortions on the list and suggested Abe see whether any of his automatic thoughts in the coming week contained one or more of these errors. Abe kept this list handy and referred to it when he was evaluating his automatic thoughts. Doing so helped him believe more strongly that perhaps an automatic thought was not true, or not completely true.

Designing Behavioral Experiments

Discussing the validity of clients' ideas that are in the form of predictions can help them change their thinking, but the change may be significantly more effective if the client has an experience that disconfirms its validity (Bennett-Levy et al., 2004). Socratic questioning may be insufficient, but it can help you decide whether it might be desirable to do a behavioral experiment. Abe had the automatic thought "I don't have enough energy to go to the homeless shelter [to volunteer]." First, we examined that thought and found that it was probably inaccurate. Then we did problem solving; we decided that Abe could plan to go for just 30 minutes and then leave if he ran out of energy. Next, we set up a behavioral experiment to see whether he would be able to follow through with this plan.

You design behavioral experiments collaboratively. When feasible, suggest that clients do the experiment right in the session to test cognitions such as the following:

> "If I tell you about how I was abused, I'll get so upset that I'll go crazy."
> "If my heart starts to pound and I'm short of breath, I'll have a heart attack."
> "If I try to read, I won't be able to concentrate."

Other experiments need to be done outside of session:

> "If I ask my sister for help, she'll turn me down."
> "If I stay in bed all day, I'll feel better."
> "If I try to pay my bills, I'll make too many mistakes."
> "If I ask my boss a question, he'll get annoyed and fire me."

Make sure to help clients draw adaptive conclusions after having done a successful behavioral experiment. Here are some questions you can ask:

> "What did you make of that experience?" or "What did you learn?" or "What do you conclude?"
> "What does this experience mean about you [or about other people or about how other people view you]?"
> "What does this experience probably mean about the future?"

Using Self-Disclosure

At times, you might use judicious self-disclosure instead of or in addition to Socratic questioning or other methods, to demonstrate how you were able to change similar automatic thoughts of your own, as illustrated below:

> "You know, Abe, sometimes I have thoughts like yours: 'I have to do the responsible thing.' But then I remind myself that I have a responsibility to take care of myself and that the world probably won't end if I can't do *everything* someone else wants me to. (*pause*) Do you think that applies to you too?"

Asking Clients for a Helpful Response

Finally, there are times when you can simply ask clients how they'd *like* to respond to an automatic thought. Sometimes they can come up with an effective response early in treatment. Sometimes you'll need to wait until they've made more progress.

ABE: When it's time to go to the reunion, I'll probably want to skip it.
JUDITH: Can you think of a more helpful way to view this?
ABE: Yeah. That it's better for me to go, even if I have to push myself. I could reconnect with people that were important to me.
JUDITH: Good. What do you think will happen if you say that to yourself?
ABE: I'll be more likely to go.

Here's another example:

JUDITH: Anything you can think of that might get in the way of telling your ex-wife that you don't want to change your holiday plans?
ABE: I don't want her to get her angry.
JUDITH: Okay, if you do have the thought "I don't want to get her angry," what do you want to be able to tell yourself?
ABE: That if this doesn't get her angry, something else will. And I should do what's good for me—not accommodate her all the time.
JUDITH: Good! Will that be enough, do you think, to go ahead and tell her you're not changing the plan?

WHEN AUTOMATIC THOUGHTS ARE TRUE

Sometimes automatic thoughts turn out to be true, and you may choose to do one or more of the following:

- Focus on problem solving.
- Investigate whether the client has drawn an invalid or dysfunctional conclusion.
- Work on acceptance and refocus on valued action.

These strategies are described below.

Focus on Problem Solving

If a client's perception of a situation appears to be valid, you might investigate whether the problem it's associated with can be solved, at least to some degree. In one session, Abe and I evaluate his automatic thought "If I don't get a job soon, I won't have enough money to pay my rent," and the evidence does indicate that this is a possibility.

JUDITH: So even if you're careful, it looks as if you might not be able to come up with rent toward the end of the year. Is it possible that you'll have a job by then?
ABE: It's possible, but what if I don't?
JUDITH: Have you thought of what you could do if that happened?
ABE: Well, I don't want to have to move in with one of my kids.
JUDITH: But you might be able to, as a last resort?
ABE: I suppose so …
JUDITH: Have you thought of anything else?
ABE: No, I don't think there's anything else I can do.
JUDITH: Have you considered getting *any* kind of job now? It could be part time or full time. Just until you find one that you really want?
ABE: No, I've been pretty focused on getting the kind of job I used to have.
JUDITH: What do you think of the idea?
ABE: I don't know. I'm so tired these days.
JUDITH: Do you think you'd need as much energy if the job were just part time? What's the worst that could happen if it turns out you *are* too tired?
ABE: I guess it wouldn't be a big deal. I could just quit.
JUDITH: Do you want to make that part of your Action Plan this week? If it turns out you can't work at all, we can brainstorm other ideas: maybe you could get a roommate or a less expensive apartment, or move in with someone else temporarily; maybe you could borrow money from your brother, even though I know you don't want to. (*pause*) And there might be other things you could do that you haven't thought of because you've been so depressed.

Investigate Invalid Conclusions

While an automatic thought might be true, the *meaning* of the thought to the client may be invalid or at least not completely valid (as illustrated below), and you can examine the underlying belief or conclusion.

JUDITH: So it looks as if you really can't concentrate well enough to do your taxes.
ABE: Yeah, I feel so bad about it.
JUDITH: What does it mean about you that you can't? Or what are you afraid will happen?
ABE: It shows there's something wrong with my brain. I might never get my concentration back.
JUDITH: Okay, can we look at that first? Is there another explanation for your difficulty in concentrating?

Work toward Acceptance and Valued Action

Some problems can't be solved and may never be solved, and clients may need help in accepting that outcome. They are likely to feel miserable if they have unrealistic expectations that an unresolvable problem will somehow, almost magically, improve. Meanwhile, they usually need assistance in learning to focus on their core values, pursue valued action, emphasize the more rewarding parts of their lives, and enrich their experience in new ways. Multiple strategies designed to enhance acceptance can be found in Hayes and colleagues (2004).

SUMMARY

It's important to address key automatic thoughts that lead to significant negative emotion or dysfunctional behavior. These thoughts are either inaccurate or unhelpful or both. Evaluating automatic thoughts is a specific skill, one at which both therapists and clients improve with repeated practice. Refrain from challenging clients' automatic thoughts and become adept at using several techniques to help clients assess the accuracy and utility of their thoughts. When automatic thoughts are true, you can evaluate clients' conclusions about a problem, do problem

solving, or employ acceptance strategies with a focus on valued action to reduce clients' distress.

REFLECTION QUESTIONS

What would you like to tell yourself if you become frustrated when learning the skill of evaluating automatic thoughts? What would you want a client to believe?

PRACTICE EXERCISE

Write down the answers to the list of questions in Figure 14.1 to evaluate one of your own automatic thoughts. Then record your answers to the questions in Figure 14.2 to evaluate another thought.

15

RESPONDING TO AUTOMATIC THOUGHTS

The previous chapter demonstrated how to help clients evaluate important negative automatic thoughts and determine the effectiveness of their evaluation in session. But when these same thoughts arise in their minds during the week, clients may not remember their responses. They will also experience additional important automatic thoughts between sessions that you didn't identify. You will find the answers to these questions in this chapter:

How do you help clients compose therapy notes to read between sessions?
How do you teach clients to use a worksheet to address other automatic thoughts between sessions?
What should you do if a worksheet isn't helpful enough?

Make sure that clients have recorded robust responses in writing (on paper or an index card, in a therapy notebook, or on a smartphone) or in an audio format (using a recording device or an app) to automatic thoughts you've addressed in session. To respond to other automatic thoughts between sessions, you can teach clients how to use questions from the previous chapter (Figures 14.1 and 14.2). Or you can use the Testing Your Thoughts Worksheet (Figures 15.1 and 15.2) or a Thought Record (Figures 15.3 and 15.4) or another technique described later in this chapter.

COMPOSING THERAPY NOTES

Having evaluated an automatic thought with clients, you'll ask them to summarize. You might pose one of the following questions:

> "Can you summarize what we've just been talking about?"
> "What do you think would be important for you to remember this week?"
> "If the situation comes up again, what do you want to tell yourself?"

When clients express a strong summary, you might say, "That's good. Would you like to write it down or would you like me to? I want to make sure you remember it this week." You will most likely ask their preference in Sessions 1 and 2 and then assume their preference hasn't changed unless they indicate it has. Abe and I evaluated his thought "I can't do it" using Socratic questioning. Then I ask him to summarize.

JUDITH: Okay, Abe, if you think about filling out the insurance forms this week and again you have the thought "I can't do it," what do you want to remind yourself?
ABE: That it's probably not true. My concentration was good enough to fill out a couple of job applications so I can probably at least get started on the forms.
JUDITH: That's good. (*Writes it down.*) Anything else?
ABE: I could ask my son for help.
JUDITH: (*writing*) That's important too. And how about that just getting started might be the hardest part?
ABE: Yeah, that's good to remember.

To make sure that what Abe writes down will be most helpful, I first ask him to express his summary verbally. This gives me a chance to add to or suggest changes to his summary.

CLINICAL TIPS

When clients' responses are superficial, confused, too brief, or too wordy, you might say: "Well, I think that's close, but I wonder if it would be more helpful to remember it this way: _____." As above, if clients' answers are reasonable but incomplete, you might ask, "Do you also want to remind yourself that _____?" If they agree, you or they can record the addition.

It's desirable for clients to read their therapy notes each morning and pull them out, as needed, during the day. They tend to integrate responses into their thinking when they have rehearsed them repeatedly. Reading notes only when encountering difficult situations is usually less effective than reading them regularly *in preparation for* difficult situations. Below are some of Abe's therapy notes. They contain responses to dysfunctional thinking and behavioral Action Plans items.

When I think "I'll never get everything done," I'll remind myself:
I should focus on what I need to do right now.
I don't have to do everything perfectly.
I can ask for help. It's not a sign of weakness.
Then I should figure out what's easiest to do and set a timer for 10 minutes. At the end of 10 minutes, I can decide whether to keep going or not.

When I think "I'd rather stay inside," I'll tell myself that I've already done the experiment of staying inside lots and lots of times and my mood doesn't get better. Chances are I'll feel better if I do go out, to get some sun, to exercise, or to do an errand.
It might feel as if I'm letting my kids down, but that's all-or-nothing thinking. I'm not doing as much for them physically, like helping them with yard work, as I did before I was depressed. But I'm still going to my grandchildren's soccer games and driving them when their parents get stuck. I should call them right now and make plans to see them.

When I want to ask Gabe for help looking online for a new job:
1. I'll remind myself it's just not a big deal. The worst that'll happen is he'll say he's too busy and then I can ask Kaitlyn instead.
2. Asking him to help is an experiment. Even if it doesn't work this time, it's good practice for me.
3. If he says he's too busy, he probably really is.
4. I should call him now and ask if I can come over today or tomorrow or vice versa.

Strategies for When I'm Anxious
1. Read my therapy notes and/or do a Testing Your Thoughts Worksheet.
2. Call Ethan and talk about sports.
3. Accept the anxiety. I don't like the feeling, but it's a normal human emotion. I can do anything with anxiety that I can do without anxiety. It will likely decrease once I turn my attention to something else.
4. Practice the mindfulness exercise.
5. Go for a walk.

CLINICAL TIPS

On a practical note, you should keep copies of your clients' therapy notes. You can photocopy them, take a picture of them and print them out, or use carbonless copy paper. You'll refer to these therapy notes when planning the next session (usually immediately before that session), when reviewing clients' Action Plans, and when reinforcing ideas you had discussed with clients in prior sessions. Also, you can provide clients with a photocopy of your notes if they lose their notes.

Audio-Recorded Therapy Notes

Ensuring that clients have written therapy notes is ideal. They can carry around a notebook or index cards to read as needed, or they can read their therapy notes on their smartphone. But some clients can't or don't like to read. Or they find it's more effective to listen to their notes. In any case, you can turn on an audio recorder or have clients use an app on their phones when developing responses to automatic thoughts; or you can note what the responses are and turn on the recorder for the last few minutes of a session, recording all responses at once. Recording and then having clients listen to an entire therapy session is often less useful. They are likely to review the recording only once during the week, instead of repeatedly listening to the most important points of the session. They may also have self-critical thoughts as they listen.

When clients aren't literate, you can ask them how they could remember what you've talked about. For example, could they draw a picture? Could

they get someone to read the notes to them? Could they listen to an audio recording?

CLINICAL TIPS

To motivate clients to read their therapy notes, use the same techniques you'd use for any Action Plan item (Chapter 8), especially linking it to their aspirations, values, and goals. Be sure to ask about obstacles that could get in the way. If they're not sure they'll have enough time, ask them how long they think it will take to read their notes. If they overestimate, you might ask them to read the notes aloud in session while you time them, so they can see that it actually takes a much shorter amount of time (usually 20–60 seconds).

USING WORKSHEETS

The Testing Your Thoughts Worksheet (Figures 15.1 and 15.2) and the Thought Record (Figures 15.3 and 15.4), also known in an earlier version as the "Daily Record of Dysfunctional Thoughts" (Beck et al., 1979), prompt clients to evaluate their automatic thoughts when they feel distressed or engage in unhelpful behavior. The worksheets elicit more information than just responding to the lists of Socratic questions in the previous chapter. It's not necessary for clients to use these worksheets if thinking about these questions is helpful enough, but many clients find a worksheet organizes their thinking and responses better. The worksheets aren't particularly useful for clients who are relatively low functioning, dislike writing, are unmotivated, or who have a low level of literacy.

Remember, thoughts may be 100% true or 0% true or somewhere in the middle. Just because you think something doesn't necessarily mean it's true.

1. When you notice your mood getting worse, or you find yourself engaging in unhelpful behavior, ask yourself the questions on the reverse side of this worksheet and write down the answers. It will probably take about 5–10 minutes.
2. Not all questions apply to all automatic thoughts.
3. If you'd like, you can use the list below to identify cognitive distortions. You may find that more than one distortion applies.
4. Spelling, handwriting, and grammar don't count.
5. It was worth doing this worksheet if your mood improves by 10% or more.

Cognitive Distortions

All-or-nothing thinking	*Example:* "If I'm not a total success, I'm a failure."
Catastrophizing (fortune-telling)	*Example:* "I'll be so upset, I won't be able to function at all."
Disqualifying or discounting the positive	*Example:* "I did that project well, but that doesn't mean I'm competent; I just got lucky."
Emotional reasoning	*Example:* "I know I do a lot of things okay at work, but I still feel like I'm a failure."
Labeling	*Examples:* "I'm a loser"; "He's no good."
Magnification/minimization	*Example:* "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm smart."
Mental filter	*Example:* "Because I got one low rating on my evaluation [which also contained several high ratings], it means I'm doing a lousy job."
Mind reading	*Example:* "He's thinking that I don't know the first thing about this project."
Overgeneralization	*Example:* "Because I felt uncomfortable at the meeting, I don't have what it takes to make friends."
Personalization	*Example:* "The repairman was curt to me because I did something wrong."
"Should" and "must" statements	*Example:* "It's terrible that I made a mistake. I should always do my best."
Tunnel vision	*Example:* "My son's teacher can't do anything right. He's critical and insensitive and lousy at teaching."

FIGURE 15.1. Testing Your Thoughts Worksheet, side 1. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

1. What is the situation? You might be having thoughts about something that just happened in the environment or something that happened inside of you (an intense emotion, a painful sensation, an image, a daydream, a flashback, or a stream of thoughts—e.g., thinking about my future). *I got a parking ticket.*
2. What am I thinking or imagining? *I'm so stupid.*

   _____

3. What is the cognitive distortion? (optional) *Labeling, overgeneralizing*

   _____

4. What makes me think the thought is true? *I shouldn't have lost track of time.*

5. What makes me think the thought is not true or not completely true? *Other people get parking tickets. It doesn't necessarily mean they're stupid.*
6. What's another way to look at this? *I just made a mistake.*

7. If the worst happens, what could I do then? *Just keep paying parking tickets, but it would be better to set an alarm on my phone so it doesn't happen again.*
8. What's the best that could happen? *I'll never get a parking ticket again.*

9. What will probably happen? *I could get another ticket, but I'll probably remember what happened this time and make sure I don't.*
10. What will happen if I keep telling myself the same thought? *I'll keep being upset with myself.*
11. What could happen if I changed my thinking? *I'd feel better.*

12. What would I tell my friend or family member [think of a specific person] *Gabe* if this happened to him or her? *It's not that big a deal. So you forgot and made a mistake. You know how to avoid doing this in the future.*
13. What would be good to do now? *Get my mind off of this. Go for a walk.*

FIGURE 15.2. Testing Your Thoughts Worksheet, side 2. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

Remember, thoughts may be 100% true or 0% true or somewhere in the middle.

Just because you think something doesn't necessarily mean it's true.

Spend just 5–10 minutes to complete the Thought Record. Note that not all questions will apply to every automatic thought. Here's what to do.

1. When you notice your mood getting worse, or you find yourself engaging in unhelpful behavior, ask yourself the questions on the reverse side of this worksheet and write down the answers. It will probably take about 5–10 minutes.
2. Not all questions apply to all automatic thoughts.
3. If you'd like, you can use the list below to identify cognitive distortions. You may find that more than one distortion applies.
4. Spelling, handwriting, and grammar don't count.
5. It was worth doing this worksheet if your mood improves by 10% or more.

Cognitive Distortions

All-or-nothing thinking	*Example:* "If I'm not a total success, I'm a failure."
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Disqualifying or discounting the positive	*Example:* "I did that project well, but that doesn't mean I'm competent; I just got lucky."
Emotional reasoning	*Example:* "I know I do a lot of things okay at work, but I still feel like I'm a failure."
Labeling	*Examples:* "I'm a loser"; "He's no good."
Magnification/minimization	*Example:* "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm smart."
Mental filter	*Example:* "Because I got one low rating on my evaluation [which also contained several high ratings], it means I'm doing a lousy job."
Mind reading	*Example:* "He's thinking that I don't know the first thing about this project."
Overgeneralization	*Example:* "Because I felt uncomfortable at the meeting, I don't have what it takes to make friends."
Personalization	*Example:* "The repairman was curt to me because I did something wrong."
"Should" and "must" statements	*Example:* "It's terrible that I made a mistake. I should always do my best."
Tunnel vision	*Example:* "My son's teacher can't do anything right. He's critical and insensitive and lousy at teaching."

FIGURE 15.3. Thought Record, side 1. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

Date/time	**Situation**	**Automatic thought(s)**	**Emotion(s)**	**Adaptive response**	**Outcome**

Date/time	Situation	Automatic thought(s)	Emotion(s)	Adaptive response	Outcome
	1. What event (external or internal) is associated with the unpleasant emotion? Or what unhelpful behavior did you just engage in?	1. What thought(s) and/or image(s) went through your mind (before, during, or after the event or unhelpful behavior)? 2. How much did you believe the thought(s)?	1. What emotion(s) (sad/anxious/angry, etc.) did you feel (before, during, or after the event or unhelpful behavior)? 2. How intense (0%–100%) was the emotion?	1. (optional) What cognitive distortion did you make? 2. Use questions below to compose a response to the automatic thought(s). 3. How much do you believe each response?	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0%–100%) is the emotion? 3. What would be good to do?
6/23	Thinking about the job interview	I'll be so nervous, I won't know what to say, and then I won't get the job. (80%)	Anxious (75%)	(Fortune-telling) I'm nervous now, but I can practice more with [my therapist]. When I was nervous in the past, like when I got a new boss, I didn't have trouble talking. (80%) If I don't get the job, I can apply for other ones. The best outcome would be that the interviewer will offer me	1. AT (50%) 2. Anxious (50%) 3. Practice

Date/time	Situation	Automatic thought(s)	Emotion(s)	Adaptive response	Outcome
				the job on the spot. The most realistic outcome is that I'll have to apply for several jobs before I get one. (90%) Thinking I won't get the job just keeps me anxious. Realizing that it's not the end of the world if I don't get it makes me feel better. (100%) I'd tell Gabe that it isn't the end of the world if he's nervous and doesn't get the job. But the more he practices, probably the less nervous he'll be. (100%) I should practice what I want to say and then act as if I'm not nervous (100%)	

Date/time	Situation	Automatic thought(s)	Emotion(s)	Adaptive response	Outcome
Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) If the worst happened, how could I cope? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of my changing my thinking? (5) If _____ [person's name] was in this situation and had this thought, what would I tell him/her? (6) What would be good to do?					

FIGURE 15.4. Thought Record, side 2. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

CLINICAL TIPS

Both worksheets contain similar questions, but the Testing Your Thoughts Worksheet has an easier readability level, and its more structured format is simpler and easier to complete. As you read in the previous chapter, first, you'll identify an important automatic thought and use one of the lists of questions with the client. If the intensity of the client's automatic thoughts and emotions decrease, you can then demonstrate how to write the answers and other information on one of the two worksheets. Note that you could pull out a worksheet immediately after identifying an important automatic thought. But if the evaluation of the thought is ineffective, clients may believe the worksheet won't be helpful to them.

In the following section, Abe and I have used the list of Socratic questions from the Testing Your Thoughts Worksheet to evaluate his thought "Gabe won't want to go with me," and he feels better. Next, I introduce that worksheet.

JUDITH: Good. Now I'd like to show you a worksheet [Figures 15.1 and 15.2] that I think will help you at home. It's called Testing Your Thoughts. It's just an organized way of writing down what we just did. Okay?

ABE: Sure.

JUDITH: (showing it to Abe) It may take some practice for you to get really good at it. So, expect to make some mistakes along the way. These mistakes will actually be useful—we'll see what was confusing, so I can prepare you better the next time. Okay?

ABE: Yeah.

JUDITH: (showing side 1 to Abe) Here at the top, it reminds you that your thoughts might or might not be true. Then it tells you when to use it. (Reads aloud.) "When you notice your mood getting worse, or you find yourself engaging in unhelpful behavior, ask yourself the questions on

the reverse side of this worksheet and write down the answers." I think it'll take you about 5 minutes to do it, maybe a little more. It also lets you know that not every question may apply, that spelling, handwriting, and grammar don't count, that if you feel 10% better, it was worth doing, and it also lists cognitive distortions.

ABE: Okay.

JUDITH: (turning to the other side) This side is self-explanatory. You just read a question, and if seems to apply, you write the answer next to it. Do you have any questions?

ABE: No, I think I understand.

JUDITH: What do you think? Is it okay if we take another automatic thought and see if you can use the worksheet?

ABE: Yeah.

Make sure that clients can successfully complete one of the worksheets in session before you suggest it as an Action Plan assignment. For some clients, it's better to introduce the Thought Record in two stages. In one session, you might teach clients to fill in the first four columns and ask them to do the same at home when they're feeling upset. If it goes well, you can then teach them to use the final two columns at the following session.

WHEN A WORKSHEET ISN'T HELPFUL ENOUGH

As with any technique in CBT, it's important not to overemphasize the importance of worksheets. Most clients, at some point, find that completing a particular worksheet did not provide much relief. If you emphasize its general usefulness and "stuck points" as an opportunity for learning, you help clients avoid automatic thoughts critical of themselves, the therapy, the worksheet, or you.

As described in the previous chapter, evaluation of an automatic thought (with or without a worksheet) may be less than optimal if clients fail to respond to their most upsetting thoughts or images, if their automatic thought is a core belief, if their evaluation and response are superficial, if

they discount their response, or if the automatic thought is part of a dysfunctional thought process.

CLINICAL TIPS

If you're not highly confident that clients will be able to use a list of questions or a worksheet effectively at home, ask them to predict what might happen.

JUDITH: If you have trouble evaluating your thoughts this week, how are you likely to feel?
MARIA: Frustrated, I guess.
JUDITH: What's likely to go through your mind?
MARIA: I don't know. I'll probably just quit.
JUDITH: Can you imagine looking at the sheet of paper and not being able to figure out what to do?
MARIA: Yeah.
JUDITH: What's going through your mind as you look at the paper?
MARIA: "I should be able to do this. I'm so stupid."
JUDITH: It's good you told me that. Do you think it would help to have a reminder that it's just a skill you'll get better at? And that I can help you at the next session?
MARIA: Yes. (Records it in the therapy notes.)
JUDITH: Do you think this response will help enough? Or do you think we should put off this Action Plan item until we have more time to practice together?
MARIA: No, I think I can try it.
JUDITH: Okay, now if you do get frustrated and have automatic thoughts, be sure to jot them down. Okay?

Here I make the Action Plan into a no-lose proposition: Either Maria does it successfully, or we'll collaboratively work on it at the next session. If frustrated, she either reads her therapy notes (and probably feels better) or keeps track of her thoughts so we can address them together.

Finally, as described in the previous chapter (p. 256), clients may be able to take a shortcut without the structure of a list of Socratic questions or a worksheet—but be careful that their responses aren't superficial. You can use two formats. One, described on pages 256–257, takes the following form: "When I think _____, I should remind myself _____." Another form is the two-column technique (automatic thoughts and responses), shown below.

Automatic thought	Response
"I want to skip the reunion."	"It's better for me to go. I could reconnect with people. And someone might have a lead for a job."

Automatic thought	Response
“If I tell Rita I don’t want to change the holiday plan, she’ll get angry.”	“If this doesn’t get her angry, something else will. I should do what’s good for me—not accommodate her all the time.”

SUMMARY

There are two major ways that clients respond to their unhelpful thinking between sessions. They can read their therapy notes, if you’ve previously evaluated the thought with them in session. Or they can use a list of Socratic questions or a worksheet to evaluate new automatic thoughts. It’s better to use the questions on a worksheet verbally with clients. If you successfully help clients evaluate an automatic thought, then you can show them how to use a worksheet that contains the same questions. When a worksheet isn’t sufficiently helpful, conceptualize the difficulty so you’ll know what to do.

REFLECTION QUESTIONS

What problems could arise in introducing a worksheet to a client? What can you do when a worksheet isn’t helpful enough? How can you reduce the likelihood that clients might become self-critical if they can’t successfully complete a worksheet?

PRACTICE EXERCISE

Identify an automatic thought that could interfere with your doing a Thought Record yourself. Then evaluate and respond to this thought using a Thought Record. Next, identify one of your dysfunctional thoughts about any situation, and use the Testing Your Thoughts Worksheet. Also, do a role play in which you introduce a client to one of the worksheets. Remember, start by helping the client successfully evaluate an automatic thought verbally, using the questions on the worksheet. Then pull out the worksheet and show the client how to fill it in.

16

INTEGRATING MINDFULNESS INTO CBT

Mindfulness has been studied intensively, sometimes as a standalone intervention and sometimes as part of a psychotherapeutic modality. In fact, mindfulness has been practiced for thousands of years. Many researchers have studied the effectiveness of mindfulness for a host of problems, including psychiatric disorders, medical conditions, and stress (see, e.g., Abbott et al., 2014; Chiesa & Serretti, 2011; Hofmann et al., 2010; Kallapiran et al., 2015), as well as relapse prevention for depression (Segal et al., 2018).

In this chapter, you'll find the answers to the following questions:

- What is mindfulness? Why use it with clients?
- What is formal versus informal mindfulness practice?
- Why should you practice mindfulness yourself?
- Which techniques do you use before introducing mindfulness?
- How do you introduce mindfulness? How do you do mindfulness of the breath, and what do you do afterward?
- What is the AWARE technique for worry?

WHAT IS MINDFULNESS?

One definition of mindfulness, reached through consensus by experts, is maintaining attention on immediate experience while taking an orientation of openness, acceptance, and curiosity (Bishop et al., 2004). It teaches you to focus on what's currently happening, either externally (such as talking to someone) or internally (such as your thoughts, emotions, or bodily or mental sensations), and you practice being willing to experience whatever is happening in a nonjudgmental way. Mindfulness is particularly useful when clients are engaged in a maladaptive thought process, such as obsessing, ruminating, worry, or self-criticism. It is also quite useful when clients are fearful of experiencing certain internal stimuli such as negative emotions, thoughts, images, cravings, or pain.

Mindfulness helps you develop a different relationship to your thoughts. Instead of engaging with them by, for example, questioning their validity, you note their presence (without judgment) and allow them to come and go on their own. The goal is not to eliminate the unhelpful thought or eliminate distressing internal stimuli—that is usually impossible and quite maladaptive. Instead, mindfulness helps you nonjudgmentally observe and accept your internal experiences, without evaluating or trying to change them. In other words, you learn to focus on the present moment while being open, accepting, and curious.

There are several kinds of mindfulness. Here are three of them:

1. Mindfulness of thoughts: for clients who excessively ruminate, worry, or try to suppress intrusive thoughts or images.
2. Mindfulness of internal stimuli: for intense emotion and other distressing internal experiences.
3. Mindfulness for self-compassion: for clients who experience a great deal of self-criticism.

In this chapter, we'll cover mindfulness of thoughts, using a focus on the breath, specifically for clients who engage in depressive rumination.

Abe's Ruminating

Here's a typical scenario in which Abe ruminates. He's sitting on the couch in his living room, watching television. But a series of depressive thoughts runs through his head and interferes with his concentration. "Why am I watching TV? I should be looking for a job. I'm wasting my life. What a

failure I am. I used to have a good life, but everything has turned bad. There's no hope. I'll never feel better." These thoughts repeat over and over. They lead to sadness and hopelessness and a heavy feeling in his body, they undermine his confidence and motivation, and he continues to sit on the couch instead of engaging in valued action.

Initially we evaluated these thoughts, and Abe felt some relief in the session. But despite practicing strong responses to them at home, the thoughts kept coming back. Abe, like a certain percentage of depressed clients, was engaged in the unhelpful thought process of rumination and had trouble disengaging from it. He believed:

> "If I think hard enough about why I lost my job and my wife, I can figure out how to avoid bad things like this in the future."
> "If I can figure out how I got depressed in the first place, I'll feel better."

He also worried to some degree and held the following belief:

> "If I predict problems, maybe I can prevent them from occurring."

These beliefs may be functional in certain situations but become highly dysfunctional when they lead to the recurrence of the same negative thoughts over and over again. After a period of time, Abe developed another dysfunctional idea:

> "Once I start thinking this way, I can't stop."

Mindfulness helped him change that belief. Responding to his thoughts was important, but it just wasn't effective enough. After learning mindfulness, Abe was able to recognize when he was ruminating, accept the experience and his negative emotion, and then choose not to engage with his thoughts. Initially, he learned to do this by focusing on his breath and later was able to focus on his external experience.

FORMAL AND INFORMAL MINDFULNESS PRACTICES

There are two types of mindfulness practices: formal and informal. In a formal mindfulness meditation, you set aside a period of time (e.g., 5 to 60 minutes), go to a quiet place, and focus your attention on a particular experience (e.g., the breath, different parts of the body, movement, thoughts, emotions, external objects, or sounds); you notice when your attention has wandered from the specified experience and nonjudgmentally bring it back to the experience. We recommend that many clients practice formal meditation for 5 minutes or so initially. They are much more likely to keep up a formal mindfulness practice if it's brief.

We also recommend informal practice, which is applying the principles of mindfulness to your day-to-day experiences, focusing on what you're doing or what is happening at the moment in an accepting, open, and nonjudgmental way. When your mind wanders to the future or past and it's not helpful to think more into it, bring it back to your current experience. Also, upon noticing an unwillingness to experience unwanted thoughts, emotions, and/or sensations, take note of the experience(s), allow them to be present without trying to control them, and bring your attention back to the task at hand.

SELF-PRACTICE

I'd like to encourage you to do what I do, that is, to use mindfulness yourself. I do a formal, 5-minute mindfulness exercise most mornings (focusing on my breathing). I do informal mindfulness at various times during the day, for example, when eating, brushing my teeth, or taking a break at work. Looking at nature and experiencing it through my senses helps me let go of anything on my mind, like work or current stressors in my life and appreciate my surroundings. When my mind wanders, I bring it back to my immediate experience. You can be mindful of almost any experience, such as walking, driving, doing tasks or chores, or engaging in self-care activities. I also do formal (if it's feasible to meditate for 5

minutes at the time) or informal mindfulness when I find that I'm caught up in a cycle of unhelpful thinking. I would advise you to take up the practice of mindfulness yourself too for three reasons:

1. It can help reduce stress and enhance your sense of well-being.
2. It can help you understand and describe the technique to clients.
3. It can help motivate clients to practice it when you use self-disclosure about the benefits you've experienced.

TECHNIQUES BEFORE INTRODUCING MINDFULNESS

Some CBT therapists teach mindfulness as a standalone skill. But we've found that integrating it into CBT treatment is much more effective for clients. Here are important strategies to use with clients *before* you introduce mindfulness, using depressive rumination as the example:

1. Educate clients about the cognitive model.
2. Examine advantages and disadvantages of rumination versus the advantages and disadvantages of focusing on the present moment (and using alternative skills like problem solving and mindfulness, when needed).
3. Use Socratic questioning to test the accuracy of what they see as the advantages of rumination.
4. Discuss how rumination interferes with their ability to live life according to their values.
5. Educate clients about how mindfulness can be helpful for their thought process.
6. Have them start the thought process right in session.
7. Ask them to rate the intensity of their negative emotion.

Then guide clients through the mindfulness exercise, for about 5 minutes, while recording it (so they can practice at home). *After* the mindfulness exercise, use the following strategies:

1. Ask clients to re-rate the intensity of their negative emotion.
2. Guide them in drawing conclusions about the experience (to further modify their dysfunctional beliefs about the thought process).

3. Collaboratively set an Action Plan item, typically practicing the formal mindfulness for about 5 minutes every morning, and then briefly using the strategy as informal mindfulness to disengage from rumination during the day.

There are two reasons we want clients to engage in the unhelpful thought process before starting an exercise such as mindfulness of the breath:

1. The exercise can serve as a behavioral experiment to test dysfunctional beliefs —for example: "Rumination is uncontrollable." Clients learn that the mindfulness exercise gives them a degree of control over their rumination—which motivates them to practice between sessions.
2. It's important to replicate the conditions clients will experience when using this strategy outside of session. If I had taught Abe mindfulness during a therapy session when he was somewhat relaxed, he may have returned the following week reporting that mindfulness didn't help throughout the week when he was distressed and ruminating.

INTRODUCING MINDFULNESS TO CLIENTS

Next, I start a mindfulness of the breath practice with Abe.

JUDITH: It sounds as if rumination isn't actually helpful. Is that right?
ABE: Yes.
JUDITH: I'd like to tell you about mindfulness. It's a technique that helps you reduce rumination by noticing your thoughts nonjudgmentally and disengaging from the thought process by letting the thoughts come and go while turning your attention to other things in the present moment.
ABE: Okay.
JUDITH: First, we need to get the rumination going so you can experience the same thoughts right now that you have at home. Can you sit back and close your eyes? If you'd rather, you can keep them open though.
ABE: (*Sits back and closes his eyes.*)
JUDITH: (*Pauses for 5 seconds.*) I'd like you to start thinking about your life and your future again, either to yourself or out loud, just like you did when you were sitting on the couch this weekend: how you should be looking for a job, how you're wasting your life, what a failure you

are, how you used to have a good life but everything has turned bad, and how there's no hope and you'll never feel better. (*Pauses for 30 seconds.*) How are you feeling?

ABE: Pretty sad.

JUDITH: On a 1 to 10 scale?

ABE: About an 8.

Next, I turn on the audio recording app on his phone.

JUDITH: Now, keep your eyes closed. I want you to focus on your breathing, on the sensations you feel as you breathe. (*Pauses for 10 seconds.*) Notice how the air feels going in and out of your nostrils; how your lungs, chest, and abdomen feel as they expand and contract. (*Pauses for 15 seconds.*) You can notice the sensations as a whole (*pause*) or focus on a specific sensation like the air going in and out of your nostrils, whichever is most comfortable to you. (*Pauses for 30 seconds.*) As you do this, you'll notice that your mind is going to wander, various thoughts will show up, or you'll get caught up in rumination from a minute ago. As you become aware of this, gently bring your focus back to the breath. (*Pauses for 45 seconds.*) No matter how many times your mind wanders, every time, just become aware that it's happened, and gently bring that focus back to the breath. (*Pauses for 30 seconds.*) There's no need to criticize yourself or get frustrated when your mind wanders because that's what our minds do; all you have to do is notice it's happened and gently bring that focus back to the breath. (*Pauses for 40 seconds.*) It's okay if you notice thoughts in the back of your mind. You don't need to force them away or make them any different. Just notice they're there and let them fade on their own, as your main focus is on those breathing sensations (*60-second pause*).

TECHNIQUES AFTER A MINDFULNESS EXERCISE

Next, I stop the recording, tell Abe he can open his eyes, and then ask him a series of questions.

"How intense is the sadness now, 0–10?"
"How was that for you?"
"What did you notice?"
"Did your mind seem to wander?"
"Were you able to bring your attention back to the breath?"
(If yes, ask) "What does that tell you about your ability to let go of rumination?"
"What happened to your emotion as you practiced mindfulness?"
"What do you make of that?"
"Was this helpful?"
"Do you think it would be good to practice this for your Action Plan?"

You should encourage your clients to use either formal (if feasible in the moment) or informal mindfulness exercises when they find themselves stuck in an unhelpful thought process or caught up in an uncomfortable internal experience. It's useful to learn a variety of formal mindfulness exercises so you can select the one that looks as if it will be most effective for an individual client (see, e.g., Hayes et al., 2004; Kabat-Zinn, 1990; Linehan, 2018; McCown et al., 2010; Segal et al., 2018). To more fully learn about integrating mindfulness into CBT, step by step, and view videos, visit *beckinstitute.org/CBTresources*.

THE AWARE TECHNIQUE

This mindful technique was designed to be used when clients worry excessively (Beck & Emery, 1985) and/or experience excessive anxiety. You can adapt it for angry or depressive rumination. Here are the steps:

1. Accept the anxiety (or other emotion).
2. Watch it.
3. Act constructively with it.
4. Repeat the steps.
5. Expect the best.

These steps are described in Appendix C. To teach clients to use this technique, ask them to briefly describe an upcoming situation in which

they predict they'll feel anxious. Then ask them to imagine the situation as if it's happening now and visualize themselves using the five steps.

SUMMARY

Mindfulness is maintaining your attention on your immediate experience while being open, accepting, and curious. Research shows that mindfulness can make treatment more effective, especially when clients are engaged in rumination, worry, obsessive thinking, continual self-criticism, or avoidance of internal experiences. Integrating mindfulness into therapy is likely to be more effective than teaching it as a standalone technique. Encourage clients to practice mindfulness daily, using formal and informal strategies.

REFLECTION QUESTION

In what ways could adopting a mindfulness practice be helpful to you?

PRACTICE EXERCISES

Do a formal mindfulness practice exercise yourself. Read the mindfulness script from earlier in this chapter into a recording device or an app on your phone. Then find a quiet space and get comfortable. You can sit on the floor or in a chair, lie down, or stand in one spot. Close your eyes (unless you'd prefer to keep them open). If you worry or ruminate too much, if you criticize yourself, if you try to avoid internal experiences such as negative emotion or negative thoughts, or if you're experiencing pain or craving, then try to reproduce the thought process or uncomfortable internal experience. (If you don't have one of those problems, then you can just start the mindfulness exercise.) As you listen to the recording, remember that it's normal to have your attention wander. Don't criticize or judge yourself. Just bring your attention back to your breath whenever you notice your mind has wandered. See how you feel after the meditation as compared to before.

Also, take 5 minutes now to do an informal practice. Look out the window or at a painting or take a walk (or engage in another activity). Use your senses to become fully aware, accepting, open, and curious about the experience. Every time your mind wanders, avoid criticizing yourself, and gently bring your focus back to the experience.

17

INTRODUCTION TO BELIEFS

In previous chapters, you learned how to identify and modify automatic thoughts, the actual words or images that go through a client's mind in a given situation and lead to distress or unhelpful behavior. This chapter, and the next, describes the deeper, often unarticulated ideas or understandings depressed clients have about themselves, others, their world, and their future that give rise to specific automatic thoughts. These ideas are often not expressed before therapy, but for the most part, you can easily elicit or infer and then test them. Traditional CBT puts a greater emphasis on the maladaptive (negative, unhelpful, dysfunctional) beliefs clients have when they're in the depressed mode. In a recovery orientation, adaptive (positive, helpful, functional) beliefs are emphasized to move clients to the adaptive mode (Beck, Finkel, & Beck, 2020).

As described in Chapter 3, beliefs may be classified in two categories: intermediate beliefs (composed of rules, attitudes, and assumptions) and core beliefs (global ideas about oneself, others, and/or the world). Maladaptive intermediate beliefs, while not as easily modifiable as automatic thoughts, are still more malleable than core beliefs. As you will learn in the next chapter, you'll use similar techniques to modify beliefs at both levels.

This chapter answers the following questions:

What are adaptive (positive) and maladaptive (negative) core beliefs, schemas, and modes?
How do you identify adaptive and maladaptive core beliefs and intermediate beliefs?
How do you decide whether and when to modify a maladaptive belief?

How do you educate clients about maladaptive beliefs?

How do you motivate clients to change their beliefs?

CORE BELIEFS, SCHEMAS, AND MODES

Core Beliefs and Schemas

Core beliefs are one's most central ideas about the self, others, and the world. Adaptive beliefs are realistic and functional and not at an extreme. Dysfunctional core beliefs are rigid and absolute, maintained through maladaptive information processing. Some authors refer to these beliefs as schemas. Beck (1964) differentiates the two by suggesting that schemas are cognitive structures within the mind. Schemas, in the Piagetian sense, have various characteristics: permeability (receptivity to change), magnitude (size compared to the individual's general self-concept), charge (low to high, indicating levels of strength), and content (Beck, 2019). The content of schemas may be cognitive (expressed in beliefs), motivational, behavioral, emotional, or physiological.

People start developing core beliefs from a very early age, influenced by their genetic predisposition, their interaction with significant others, and by the meaning they put to their experiences and circumstances. Then, when a thematically related situation arises, the schema containing one of these core beliefs becomes activated (Figures 17.1 and 17.2). In a depressed state, clients' negative schemas can be continuously activated. For example, before the onset of his acute episode, Abe had seen himself as a reasonably competent person. But as he was becoming depressed, he started to see himself as incompetent.

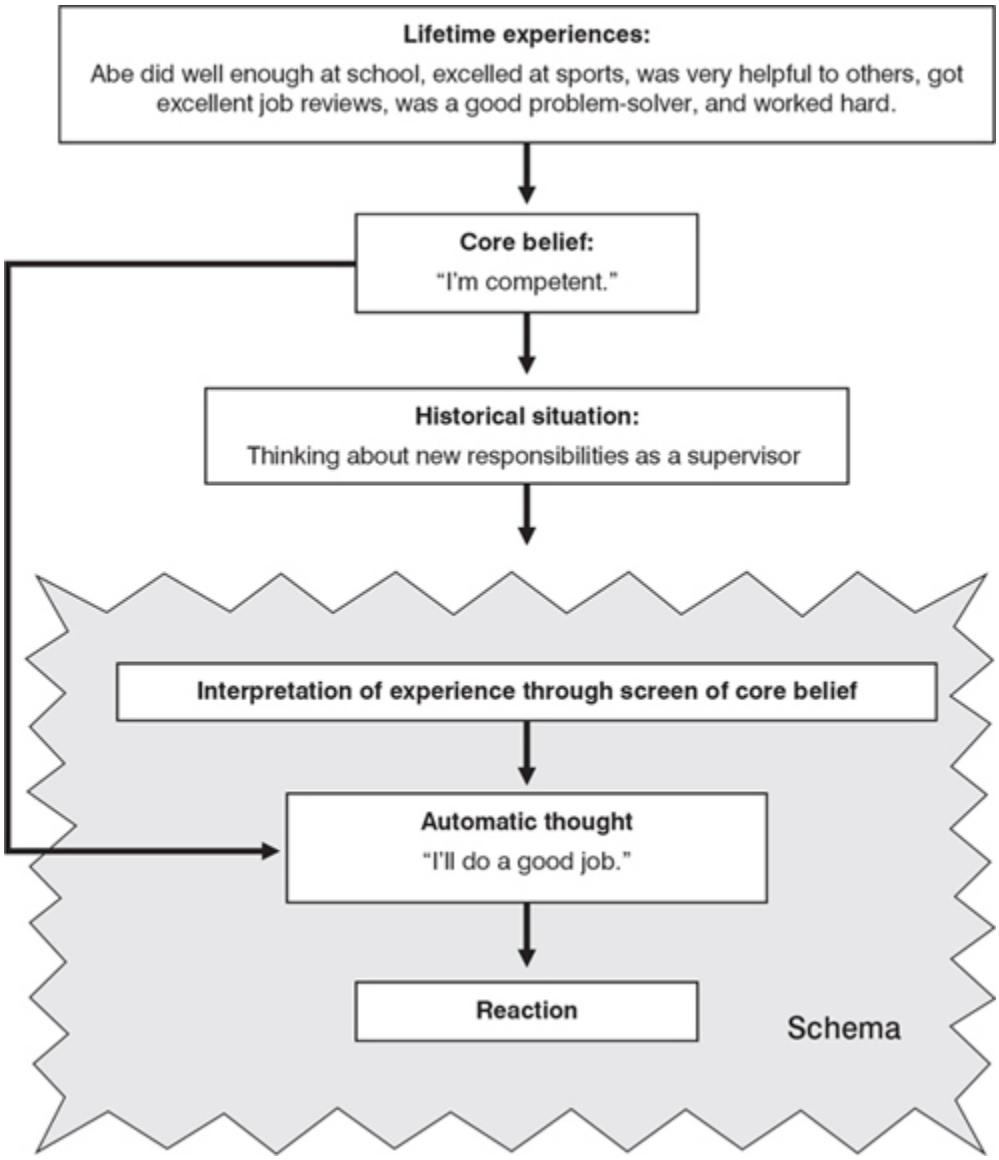

Lifetime experiences:
Abe did well enough at school, excelled at sports, was very helpful to others, got excellent job reviews, was a good problem-solver, and worked hard.
Core belief:
"I'm competent."
Historical situation:
Thinking about new responsibilities as a supervisor
Interpretation of experience through screen of core belief
Automatic thought
"I'll do a good job."
Reaction
Schema

FIGURE 17.1. Impact of adaptive schema activation.

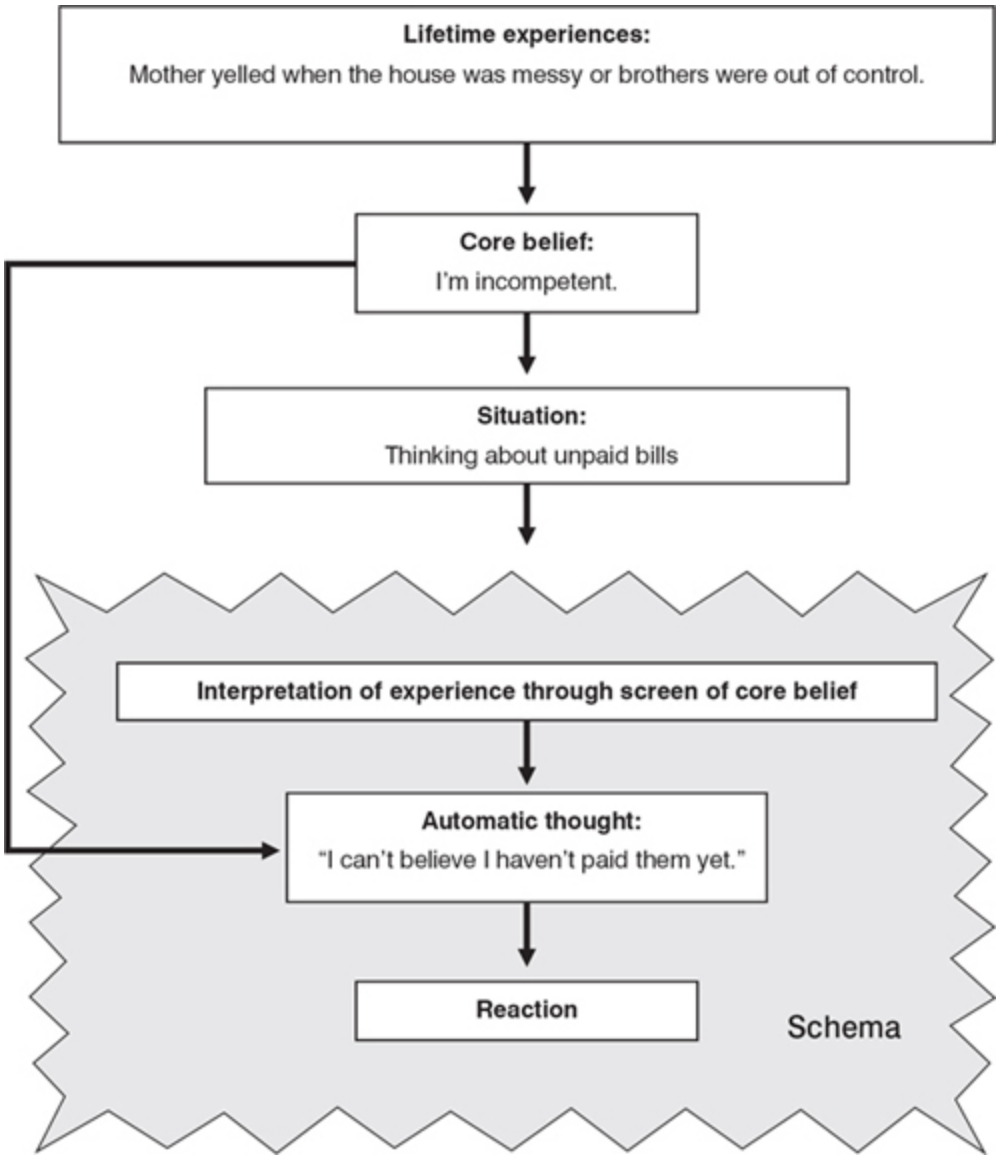

Lifetime experiences:
Mother yelled when the house was messy or brothers were out of control.
Core belief:
I'm incompetent.
Situation:
Thinking about unpaid bills
Interpretation of experience through screen of core belief
Automatic thought:
"I can't believe I haven't paid them yet."
Reaction
Schema

FIGURE 17.2. Impact of maladaptive schema activation.

Once a schema is activated, three things generally happen:

1. The client interprets this new experience in accordance with the core belief.
2. The activation of the schema strengthens the core belief.
3. Other kinds of schemas become activated too.

One reason we emphasize modifying dysfunctional cognitive (and also behavioral) schemas in traditional CBT is their impact on the other schemas.

Modes

Clusters of interrelated and co-occurring schemas are termed "modes." At every session, we seek to deactivate the depressive (or "client/patient") mode and activate the adaptive mode (Beck et al., 2020).

The Adaptive Mode

For much of their lives, most people maintain primarily realistic and balanced core beliefs that are at least somewhat positive (e.g., "I am substantially in control"; "I can do most things competently"; "I am a functional human being"; "I can protect myself when I need to"; "I am generally likable"; "I have worth"). When clients are in an adaptive mode, schemas are more functional; their beliefs more realistic (see Figure 3.1, p. 31) and flexible. Their negative core beliefs tend to be relatively latent. The adaptive mode has

- cognitive schemas such as effectiveness, lovability, and worth;
- motivational schemas to promote activity;
- affective schemas of hope, optimism, sense of well-being and purpose, and satisfaction;
- behavioral schemas of approach (and sometimes healthy avoidance); and
- physiological schemas of normal levels of energy, appetite, libido, and so forth.

When clients operate in this mode, they tend to interpret their experiences clearly, without a great deal of distortion. They may have ups and downs in their moods, but they function more highly than when they are in a depressive mode.

The Depressive Mode

When clients are in the depressive mode, their schemas are dysfunctional, their beliefs more distorted and extreme (Figure 3.2, p. 33). Their positive beliefs tend to be latent. The depressive mode has

- cognitive schemas such as helplessness, unlovability, and worthlessness;
- motivational schemas to conserve energy;
- affective schemas of sadness, hopelessness, and sometimes irritability, guilt, anger, and/or anxiety;
- behavioral schemas of avoidance and withdrawal; and
- physiological schemas of fatigue, decreased (or increased) appetite, and decreased libido, among others (Clark et al., 1999).

Beck (1999) theorized that negative core beliefs about the self fall into two broad categories: those associated with helplessness and those associated with unlovability. A third category, associated with worthlessness (Figure 3.2), has also been described (J. S. Beck, 2005). When clients are depressed, their negative core beliefs may primarily fall into one of these categories, or they may have core beliefs in two or all three categories. Some have just one belief within a category; others have multiple beliefs within one category.

Sometimes it's clear in which category a given negative core belief belongs, especially when clients actually use words such as "I am helpless" or "I am unlovable." At other times, it's not as clear. For example, depressed clients may say, "I'm not good enough." You need to find out the *meaning* of cognitions like these to determine whether clients believe they are not good enough because they haven't achieved enough (helpless category), or if they believe they're not good enough for others to love them (unlovable category). Likewise, when clients say, "I'm worthless," they may mean that they don't achieve highly enough (helpless category) or that they won't be able to gain or maintain love and intimacy with others because of something within themselves (unlovable category). The cognition "I'm worthless" falls in the worthlessness

category when clients are concerned with their immorality or toxicity, not their effectiveness or lovability.

Core Beliefs about Others, the World, and the Future

Clients without psychological problems generally have balanced views of other people and the world (e.g., "I can trust many people but not everyone"; "Most people will be either neutral or benign toward me, though some might not"; "Many parts of my world are safe enough but other parts can be dangerous"; "The world is complex, with good, neutral, and bad parts"). Individuals with psychological difficulties, though, may have negative and relatively absolutistic core beliefs about other people and their worlds: "Other people are untrustworthy/superior to me/critical"; "Other people will hurt me"; "The world is a rotten place"; "The world is dangerous."

When individuals aren't depressed, they generally have a balanced view of the future, understanding that they will have many positive, neutral, and negative experiences. When clients are depressed, though, they usually see their future as dark, as unremittingly unhappy, as having little or no satisfaction or pleasure, and as being beyond their control.

Fixed, overgeneralized negative ideas often need to be evaluated and modified, in addition to negative core beliefs about the self. Ideas that are more reality based often need to be strengthened by, for example, asking clients to draw conclusions about their neutral and positive experiences ("What does this experience show about you? About others? About the world? What does it say about what your future could be like?").

Abe's Core Beliefs

Before Abe became depressed, he recognized when he was acting competently and being effective. He encountered some situations that were similar to those he faced during his depression. But the schemas containing his adaptive beliefs were activated and so he interpreted those situations differently. He viewed signs of possible incompetence as situation specific; for example, when he made a minor error, he thought, "Oh, I shouldn't have made that mistake. Oh, well," and his mood didn't

drop. When he forgot his daughter's anniversary, he thought, "No wonder I forgot. Things have been so busy recently."

As Abe was becoming depressed, his positive schemas became deactivated and his negative schemas containing the cognitions "I am incompetent/a failure" and "I am helpless/out of control" became almost fully activated. When he was firmly in the depressive mode, he interpreted situations in a highly negative, global way, as confirming these negative beliefs. Seeing himself as incompetent or ineffective was very distressing to Abe; it violated his important, strongly held values. He had always prided himself on being responsible and productive and doing a good job. He perceived that he could no longer fulfill those important values. As illustrated by the information-processing model on page 34, Abe began to overemphasize and overgeneralize negative data, contained in negative rectangles, continually reinforcing his belief that he was incompetent and a failure. For example, he got an overdue notice for a bill in the mail. He immediately understood this information as confirming his incompetence.

At the same time, Abe failed to recognize a significant amount of positive data related to his schema of relative effectiveness—such as continuing some of his usual activities even though the depression made it very difficult to do so (e.g., researching which appliance his daughter should buy for her kitchen). Note that had he become overwhelmed by the choices, he would have interpreted that experience in a negative light, as confirming his maladaptive core belief. These positive triangles "bounced off" the schema and did not get incorporated. Abe also discounted much positive information through his "Yes, but …" interpretations of his experiences ("Yes, I finally got rid of all the papers that had piled up in the living room, but I should never have let it get so bad"). When he successfully negotiated a reduction in his cable bill the next day, his mind automatically discounted this positive evidence too ("I should have done this months ago"). These two experiences were contrary to his negative core beliefs. Their positive triangles were, in essence, changed into negative rectangles.

Abe was not consciously processing information in this dysfunctional way. This kind of information processing is a symptom of depression and arises automatically. I recognized that it would be important to work directly on modifying Abe's negative core beliefs, not only to alleviate his

current depression, but also to prevent or reduce the severity of future episodes.

CLINICAL TIPS

We usually work both indirectly and directly on strengthening positive core beliefs early in treatment. Most clients aren't ready to directly evaluate their negative core beliefs though until somewhat later in treatment. If you try to evaluate a negative belief too early, the client might think, "[My therapist] doesn't understand me. If she did, she would know [that my core belief is true]." Eliciting strong, negative beliefs can trigger intense negative emotion that could lead to early dropout from treatment.

IDENTIFYING ADAPTIVE CORE BELIEFS

You start identifying core beliefs that are more realistic and adaptive as early in treatment as possible. At the evaluation or first session, you can ask clients to describe the best period in their life. Then ask them how they viewed themselves during that period, and if relevant, how they viewed others and the world. Also ask how other people viewed them.

JUDITH: Abe, looking back at your history, when were you at your best?
ABE: I guess that would have been after high school.
JUDITH: Why was that your best time?
ABE: I had moved out of the house. I liked living independently. My best friend was my roommate. I was working in construction and the foreman really liked my work.
JUDITH: What else?
ABE: (*Thinks.*) Well, I was in really good shape, I had a lot of girlfriends—until I met my wife, that is. I liked hanging around with my buddies …
JUDITH: How did you see yourself?
ABE: As a good guy.
JUDITH: As likeable, helpful, worthwhile?
ABE: Yeah.
JUDITH: As competent? In control?
ABE: Yeah, pretty much.
JUDITH: Did other people see you that way too?
ABE: (*Thinks.*) Yeah, they probably did.

JUDITH: So, you had a pretty healthy view of yourself and so did others; sounds like it was pretty accurate too.
ABE: I guess so.
JUDITH: Is that how you see yourself now?
ABE: Not at all. I just feel like I can't do anything right. I'm a failure.
JUDITH: Part of what we're going to do in therapy is to find out whether this idea, that you're a failure, is accurate, or whether it's actually a depressed idea. Maybe you're a competent person who is currently depressed.

At a future session, you can ask clients about their view of themselves before they became depressed. (The list of positive qualities on page 47 can help.) It's useful to attribute their deterioration in functioning as due to their condition, instead of to their innate characteristics.

JUDITH: Can we talk about the time before Joseph was hired, when you were doing well at your job? How did you see yourself? Did you think you were incompetent, a failure?
ABE: No; I mean, I wasn't perfect, but I did a good job.
JUDITH: So was your belief "I'm basically competent"?
ABE: Yeah.
JUDITH: Good. Now the depression is interfering with your being able to *act* as competently as you'd like. And I'll help you with that. But I want you to know that you haven't *lost* your competence. You haven't *become* an incompetent person. It's your depression. Okay?
ABE: (*Nods.*)
JUDITH: Am I right about this? Even though your depression is strong, you're still getting up every day? You're getting dressed and taking care of your basic needs? You're going to your grandsons' games and helping your cousin? (*pause*) Do these things show you're competent at least in these ways?
ABE: Yeah, I guess so.
JUDITH: And as you recover, you'll be able to act more and more competently and productively.

CLINICAL TIPS

When clients can't express their former adaptive beliefs, you mentally devise a new, more realistic, and functional belief and guide clients toward it. This belief should be balanced. For

example:

Old core belief	New core belief
"I'm (completely) unlovable."	"I'm generally a likable person."
"I'm bad."	"I'm okay."
"I'm powerless."	"I have control over a lot of things."
"I'm defective."	"I'm normal, with both strengths and weaknesses."

IDENTIFYING MALADAPTIVE CORE BELIEFS

Several strategies are useful in eliciting clients' negative core beliefs, including

- looking for *central themes in their automatic thoughts*,
- using the *"downward arrow" technique*, and
- watching for *core beliefs expressed as automatic thoughts*.

Looking for Central Themes in Automatic Thoughts

Whenever clients present data (problems, automatic thoughts, emotions, behavior, history), you "listen" for the category of core belief whose schema seems to have been activated. For example, when Abe expresses negative thoughts about being unable to apply for jobs, about wasting his time by watching television, and about making mistakes in paying bills, I hypothesize that a core belief in the helpless category has been operating. When Maria expresses anxiety about calling a friend, when she consistently expresses thoughts of others not caring about her, and when she fears there's something wrong with her and so she won't be able to sustain a relationship, I hypothesize that a core belief in the unlovable category has been activated. (Actually, it's more correct to say that the schema that contains the core belief has been activated.)

Early in treatment, you may hypothesize just to yourself. Sharing your hypotheses about clients' core beliefs may evoke strong emotion, and they may begin to feel unsafe. Later in treatment, you might review with clients related automatic thoughts they've had in a variety of situations and then

ask them to draw a conclusion as to an underlying pattern ("Abe, do you see a common theme in these automatic thoughts?"). When confirming a hypothesis you've made with clients, it's important to figure out which category a core belief falls into and which word or words clients themselves use. It's also important to ascertain whether the client is using different words to express the same belief.

JUDITH: Abe, when you say you're a failure, is that the same idea as when you say you're incompetent? Or are they different?
ABE: It's really the same. I'm a failure because I'm so incompetent.

The Downward Arrow Technique

The downward arrow technique helps you identify clients' negative core beliefs. It involves asking clients to assume their automatic thoughts (ones with recurrent themes) are true and then questioning them about the *meaning* of their automatic thoughts. Doing so can arouse increased negative emotion though, so you usually wouldn't use this technique in the first few therapy sessions.

First, identify a key automatic thought whose theme is recurrent; then find out what clients believe this thought means about them.

JUDITH: Okay, to summarize, you were looking around your apartment and you thought, "It's so messy. I should never have let it get this way?"
ABE: Yes.
JUDITH: We haven't looked at the evidence to see if these thoughts are true. But I'd like to see if we can figure out *why* you had those thoughts. Let's assume for a moment that your apartment *is* too messy and you shouldn't have let it get like that. What would that mean about you?
ABE: I don't know. I just feel so incompetent.

You can phrase the downward arrow question in different ways:

"If that's true, so what?"
"What's so bad about …?"
"What's the worst part about …?"

Worded in these ways, clients may respond with another automatic thought or an intermediate belief. If so, you can ask what this new cognition means about them if you want to get to the negative core belief about the self.

Core Beliefs Expressed as Automatic Thoughts

A client may actually articulate a belief as an automatic thought, especially when depressed.

JUDITH: What went through your mind when you realized you got a late fee because you had forgotten to pay the bill?
ABE: I can't do anything right. [automatic thought] I'm so incompetent. [automatic thought and core belief]

CLINICAL TIPS

When clients have difficulty identifying their negative core beliefs, these techniques may help. You can hypothesize about a belief and ask the client to reflect on its validity:

> "Maria, in a bunch of situations you seem to think, 'People won't want to be with me' or 'What if I say the wrong thing?' I wonder whether you believe that you are somehow unlovable or unlikable?"

Or you can present them with the list of core beliefs on page 33.

JUDITH: Maria, what did it mean to you when you realized the whole day had gone by and you hadn't gotten much done? What did that say about you?
MARIA: I'm not sure. I was just so upset.
JUDITH: Could you look at this list of core beliefs and tell me whether any of the words capture how you were feeling about yourself?

CLINICAL TIPS

The problematic situation itself is not always a good guide to what clients' core beliefs are. For example, a client is frustrated by her inability to get others to listen to her. Although her distress occurs only in interpersonal situations, she doesn't believe she is unlovable; she believes she is powerless to get what she wants from others. Another client feels like a worthless human being, not because he cannot achieve or be useful (helpless beliefs) and not related to his relationships (which otherwise could have indicated an unlovable belief). He believes he is a bad, immoral person, a sinner (which is in the worthless category) because of his highly negative innate qualities.

IDENTIFYING MALADAPTIVE INTERMEDIATE BELIEFS

In Chapter 3, we discussed three categories of intermediate beliefs: assumptions, attitudes, and rules. There are several techniques you can use to identify them.

- Recognizing when intermediate beliefs are expressed as automatic thoughts.
- Directly eliciting an intermediate belief.
- Reviewing a belief questionnaire.

Recognizing When Intermediate Beliefs Are Expressed as Automatic Thoughts

Most automatic thoughts are situation specific—for example: "I shouldn't have let my friend down when he asked me to help him with his mother"; "It's really bad that I forgot my niece's birthday"; "If I try to help my daughter with her class project, I'll do a poor job." But some automatic thoughts express more general ideas—for example: "It's terrible to let people down"; "I should always do my best"; "If I try to do anything difficult, I'll fail." These latter cognitions are relevant across multiple situations and so are both automatic thoughts and intermediate beliefs.

Directly Eliciting an Intermediate Belief

Many intermediate beliefs contain a dysfunctional coping strategy. You can identify these beliefs by asking clients directly about these behavioral patterns. The general question focuses on the meaning or outcome of using the behavior or *not* using the behavior. Or you can start with a rule or attitude and ask questions to change it into an assumption. We often do this to find out why the client holds this rule or attitude; assumptions link the behavior to the core belief. Here are a few examples of the kinds of questions you can ask:

THERAPIST: What's your belief about asking for help? [Avoiding asking for help is a coping strategy.]

CLIENT: Oh, asking for help is a sign of weakness, incompetence.

THERAPIST: What's the worst that could happen if you don't try to look your best? ["I should always look my best" is the client's rule.]
CLIENT: People will think I'm unattractive; they won't want me around.

THERAPIST: What would it mean to you if you didn't achieve highly? ["I have to achieve highly" is the rule; "It's terrible to be mediocre" is the client's attitude.]
CLIENT: It shows I'm inferior to other people.

THERAPIST: What's bad about experiencing negative emotion? ["I shouldn't let myself get upset" is the rule; "It's bad to experience negative emotion" is the attitude.]
CLIENT: If I do, I'll lose control.

THERAPIST: What are the advantages of not sticking out in a crowd? [Avoiding sticking out in a crowd is a coping strategy.]
CLIENT: People won't notice me. They won't see that I don't fit in.

THERAPIST: How would you fill in this blank? If I even try to make plans with other people, then _____? [Avoiding making plans is a coping strategy.]
CLIENT: They'll turn me down because I have nothing to offer them.

Evaluation of conditional assumptions through questioning or other methods often creates greater cognitive dissonance than does evaluation of the rule or attitude. It is easier for Abe to recognize the distortion and/or dysfunctionality in the assumption "If I please other people, they won't hurt me" than the related rule ("I should please others all the time") or attitude ("It's bad to displease others").

Reviewing a Belief Questionnaire

Questionnaires can also help you identify clients' beliefs (see, e.g., the Dysfunctional Attitude Scale [Weissman & Beck, 1978] or the Personality Belief Questionnaire [Beck & Beck, 1991]). Many clients in particular hold important beliefs about experiencing negative emotion (see Leahy,

2002). Careful review of items that are strongly endorsed can highlight problematic beliefs.

DECIDING WHETHER TO MODIFY A DYSFUNCTIONAL BELIEF

Having identified an intermediate or core belief, you need to figure out whether it's worth spending time on. You usually work on beliefs linked with an issue a client has put on the agenda or with an obstacle to reaching a goal. Here are some questions to ask yourself:

> "What is the belief?"
> "Does it lead to significant emotional distress or significant maladaptive behavior?"
> "Does the client believe it strongly and broadly?"
> "Does it significantly interfere with achieving his/her goals and aspirations or engaging in valued action?"

When clients strongly endorse more than one negative belief about an issue or obstacle, you usually focus on the one that is associated with the greatest degree of negative emotion or dysfunctional behavior.

DECIDING WHEN TO MODIFY A DYSFUNCTIONAL BELIEF

At the beginning of treatment, you work on automatic thoughts whose theme is indicative of a dysfunctional core belief. You begin to work *directly* on modifying the negative core belief as early in treatment as possible. Once clients change these beliefs (or decrease the intensity of these beliefs), they're able to interpret their experiences in a more objective, functional way. They begin to view situations more realistically, feel better, and act more adaptively. But you may need to wait until the middle of treatment to do this with some clients, especially those with beliefs that are long-standing, rigid, and overgeneralized.

In this latter case, you'll teach clients the techniques of identifying, evaluating, and adaptively responding to automatic thoughts before using the same tools for dysfunctional beliefs. Note that you may unwittingly try to evaluate a core belief early in treatment because it has been expressed as an automatic thought. Such evaluation may have little effect.

Having identified an important dysfunctional belief, you can ask yourself these questions to figure out whether to work on the belief at the time:

"Does the client believe that cognitions are ideas and not necessarily truths, and that evaluating and responding to these kinds of ideas helps them feel better and/or act in a more functional way?"
"Will the client be able to cope with the distress she is likely to feel when the core belief is exposed?"
"Will the client be able to evaluate the belief with at least some objectivity?"
"Is the therapeutic relationship strong enough? Does the client trust me and perceive me as understanding who he really is? Do I have credibility with the client?"
"Will we have enough time in the session today to make at least a little progress in evaluating the belief?"

EDUCATING CLIENTS ABOUT DYSFUNCTIONAL BELIEFS

You've identified an intermediate or core negative belief, determined that it is significantly distressing to the client and is associated with significant impairment, and collaboratively decided that the time is right for you to start working on it. Next, you may decide to educate the client about the nature of beliefs in general, using a specific belief as an example.

Important Concepts about Beliefs

It is important for clients to understand the following:

- Beliefs, like automatic thoughts, are ideas, not necessarily truths, and can be tested and changed.

- Beliefs are learned, not innate, and can be revised. There is a range of beliefs that the client could adopt.
- Beliefs can be quite rigid and "feel" as if they're true—but be mostly or entirely untrue.
- Beliefs originated through the meaning clients put to their experiences as youth and/or later in life. These meanings may or may not have been accurate at the time.
- When relevant schemas are activated, clients readily recognize data that seem to support their core beliefs, while discounting data to the contrary or failing to process the data as relevant to the belief in the first place.

Posing a Hypothesis about the Problem

When I educated Abe about his core belief, I suggested two possibilities about the problem. (He had previously confirmed the conceptualization I had presented.)

JUDITH: [summarizing] It sounds as if this idea, that you're incompetent, could get in the way of your applying for jobs. Is that right?

ABE: Yeah.

JUDITH: Can we talk about that idea for a moment? I'd like to figure out what's going on. Either the problem is that you really *are* incompetent, and if so, we'll work together to make you more competent … or maybe that's not the problem at all. Maybe the problem is that you have a *belief* that you're incompetent, when you're really not. And sometimes the belief is so strong that it prevents you from even *finding out* whether you could do something well.

ABE: I don't know.

JUDITH: I think there are two things we need to do. One is to have you recognize when you *are* being competent and set up more experiences where you can use your competence. The second is to see whether you really *are* incompetent when you *feel* incompetent.

Using a Metaphor to Explain Information Processing

Later I explain core beliefs to Abe, in small parts, making sure he understands as I proceed. I use the metaphor of a screen.

JUDITH: This idea, "I'm incompetent," is what we call a negative core belief. If it's okay, I'd like to tell you about core beliefs. They're more difficult to change than automatic thoughts.

ABE: Okay.

JUDITH: First of all, a negative core belief is an idea that you may not believe very strongly when you're not depressed. On the other hand, we'd expect you to believe it almost completely when you *are* depressed, even if there's evidence that it's not true. (*pause*) Follow me so far?

ABE: Yes.

JUDITH: When you get depressed, this idea becomes quite strong. (*motioning with my hands*) It's as if there's a screen around your head. The idea that you're incompetent is written on it a billion times. Anything that fits in with the idea that you are incompetent goes straight through the screen and into your mind. But any information that contradicts it doesn't fit through. So you don't even *notice* the positive information, or you discount it in some way so it *will*. (*pause*) Do you think you might be screening information like this?

Next, I question Abe to see whether the metaphor seems to fit his experience.

JUDITH: Well, let's see. Looking back at the past few weeks, what evidence is there that you *might* be competent? Or what would *I* think you did competently?

ABE: Umm … I figured out how to fix my grandson's robot.

JUDITH: Good! And did that evidence go right through the screen? Did you tell yourself, "I figured out how to fix the robot. That means I'm competent"? Or anything like that?

ABE: No. I guess I thought, "It took me a long time to figure it out."

JUDITH: Oh, so it looks like the screen *was* operating. Do you see how you discounted the evidence that contradicted your core belief "I'm incompetent"?

ABE: Hmm.

JUDITH: Can you think of any other examples from this week? Situations where a reasonable person might think something you did showed you were competent, even if you didn't?

ABE: (*Thinks for a moment*.) Well, I helped out at the church. They're fixing up the basement. But that doesn't count; anyone could have done it.

JUDITH: Good example. Again, it sounds as if you didn't recognize evidence that didn't fit with your idea "I'm incompetent." I'm going to let you think about how true the idea is that *anyone* could have done what you did. Maybe this is another instance of not giving yourself credit, when another person might have thought it was evidence that you're competent.

ABE: Well, the minister thanked me a lot.

JUDITH: And how many times this week did you take care of your basic needs: showering, brushing your teeth, eating meals, getting to bed at a reasonable hour?

ABE: Every day.

JUDITH: And how many times this week did you say something like "Brushing my teeth shows I'm competent"; "Getting my meals shows I'm competent"; and so on?

ABE: None.

JUDITH: What would you have said to yourself if you *hadn't* done those things?

ABE: Probably that I was incompetent.

JUDITH: So do you think the screen was operating, discounting what you did or not even registering what you did?

Determining When the Belief Originated or Became Maintained

Next, I ask Abe about prior experiences in which he recalled having this belief.

JUDITH: Do you remember feeling incompetent like this at other times in your life too? As a child?

ABE: Yeah, sometimes. I remember my mother yelling at me because the house was messy or my brothers were out of control.

JUDITH: Any other times?
ABE: (*Thinks.*) Yeah, when I got my first job after high school. And, I guess, when I started the next job. But that was just for the first few weeks.
JUDITH: Okay, just to summarize: "I'm incompetent" seems to be a core belief that started when you were a kid. But you didn't believe it all the time. I'm guessing that for most of your life, until the depression set in, you've believed you're reasonably competent. But now the screen is operating.

Explaining Beliefs Using a Diagram

Next, I hand drew the diagram in Figure 17.2 to summarize what we had discussed in this session.

JUDITH: Abe, can I show you how all this looks on a diagram?
ABE: I think that would help.
JUDITH: Okay, we start with childhood experiences. It sounds as if you felt incompetent at times when your mother yelled at you. (*Draws partial diagram.*) Is that right?
ABE: Yes.
JUDITH: And now, when you're depressed, is this how you understand what's going on? If you don't do something as well as you think you should have, it means to you that you're incompetent? For example, this week you saw the bills on the table and you had the thought, "I can't believe I haven't paid them yet." Is that right?
ABE: Yes.
JUDITH: Just to confirm, what did it mean to you that you hadn't paid them?
ABE: That I was incompetent.
JUDITH: So, I think the experience looks like this. (*Adds to diagram and shows it to Abe.*) Now can you see why you had this automatic thought?

MOTIVATING CLIENTS TO MODIFY DYSFUNCTIONAL BELIEFS

Even suggesting that a dysfunctional belief may not be true, or not completely true, can be anxiety provoking for some clients. If so, you can draw a chart (see p. 328) and ask clients to identify advantages and disadvantages of maintaining their dysfunctional core belief and advantages and disadvantages of believing the more adaptive belief. Ask them what they conclude from this analysis.

When clients need additional motivation, you can ask them to visualize a day in their life several years from now, first having maintained their negative core belief as is, and then believing their new core belief for quite a long time. You can say something like this:

> "I'd like you to imagine a day in your life _____ years from now; so it's the year _____. You haven't changed your core belief that you are _____. So you've believed it day in and day out for _____ more years. It's gotten stronger and stronger with each passing day, and week, and month, and year. (*pause*) Now I'd like to ask you some questions. (*pause*) See how well you can picture yourself and your experience in your mind's eye.
>
> "How do you feel about yourself?"
> "How far along are you in achieving [each of your aspirations and goals]?"
> "To what degree are you living in accordance with your values?"

Next, tell clients:

> "I'd like you to imagine how your belief has affected various parts of your life. Remember, your core belief is so much stronger than it is today. Really try to picture each part of your life, as I ask you about it. And think about how much enjoyment or satisfaction you'll likely be experiencing … Where do you see yourself waking up? In the same place as today? Or someplace different? … What does it look like? …

> How much enjoyment or satisfaction do you get from where you live?"

Then you can ask about other relevant areas—for example: specific relationships, their job, how they spend their leisure time, their sense of spirituality, their creativity, their physical health, and their household management. Make sure to find out how much or how little enjoyment or satisfaction they get from each. Finally, ask them:

> "What is your general mood like? What do you conclude from having believed that you are _____ for such a long time?"

Now repeat the same questions for a second scenario, but start out by saying:

> "Now I'd like you to imagine that you've believed your *new* core belief, that you are _____. You've believed it more and more strongly day after day, week after week, month after month, and year after year for _____ years. See how well you can picture yourself and your experience in your mind's eye. Tell me about these same areas, and how much enjoyment and satisfaction you get from each."

Then ask:

> "What is your general mood like? What do you conclude from having believed that you are _____ for so many years?"

SUMMARY

You begin to formulate a hypothesis about clients' core beliefs whenever they provide data in the form of their automatic thoughts (and associated meanings) and reactions (emotions and behaviors). You hypothesize whether cognitions seem to fall in the helpless, unlovable, or worthless

categories. You identify both intermediate and core beliefs in many ways. You can look for the expression of a belief in an automatic thought, provide the conditional clause ("If …") of an assumption and ask the client to complete it, directly elicit a rule, use the downward arrow technique, recognize a common theme among automatic thoughts, ask clients what they think their belief is, or review the client's belief questionnaire.

REFLECTION QUESTIONS

How can you identify positive core beliefs? Negative core beliefs? How can you explain a maladaptive core belief to a client? How can you motivate the client to change the belief?

PRACTICE EXERCISE

Imagine that you have a core belief that you are (emotionally) vulnerable. Imagine at least one lifetime experience that might have led to the development or strengthening of this belief and how this belief affects your perception of a particular situation. Write down this imagined conceptualization using Figure 17.2 as a guide.

18

MODIFYING BELIEFS

In the previous chapter, we discussed how to identify important positive and negative beliefs, how to explain beliefs to clients, and how to motivate them to modify their beliefs. When clients are in a maladaptive mode such as depression, it's important to

- develop and strengthen realistically positive beliefs to activate the adaptive mode (which is emphasized to a greater degree in a recovery orientation), and
- modify their unrealistic, negative beliefs to deactivate the depressive mode (which is emphasized to a greater degree in traditional CBT).

In this chapter, you'll read about strengthening positive beliefs first and weakening negative beliefs second. In practice, you'll work on both kinds of beliefs at most sessions, either directly or indirectly. The techniques apply to both intermediate and core beliefs. Here are the questions that you'll find answers to in this chapter:

How do you strengthen adaptive beliefs?

How do you modify intermediate and core beliefs?

STRENGTHENING ADAPTIVE BELIEFS

Most people, unless they have strong personality disorder traits, have reasonably balanced, adaptive, realistic beliefs. But the schemas containing some of these positive beliefs become deactivated when clients are in the depressive mode. It's important to reinforce these more positive beliefs (Ingram & Hollon, 1986; Padesky, 1994; Pugh, 2019) throughout treatment by helping clients engage in activities that could bring them a sense of mastery, pleasure, connection, and empowerment. Other important strategies include

- eliciting positive data and drawing helpful conclusions about their experiences,
- eliciting the advantages of believing adaptive beliefs,
- pointing out the meaning of positive data,
- referencing other people,
- using a chart to collect evidence,
- inducing images of current and historical experiences, and
- acting "as if."

Eliciting Positive Data and Drawing Conclusions

I started identifying and working to strengthen Abe's positive, adaptive beliefs from the beginning of treatment, in many ways. In the following examples, I primarily address Abe's core belief of incompetence/failure. Here's what I did when we initiated therapy and throughout our treatment:

- At the beginning of each session, I asked Abe, "What positive things happened since I saw you last? What positive things did you do? [or "When this week did you feel even a little better?"] Then I asked, "What do you conclude about [these experiences]? What do these experiences say about you?"
- I asked Abe to keep a credit list of everything he did each day that was even a little difficult but that he did anyway.
- Once we identified an important adaptive belief ("I'm competent, with strengths and weaknesses like everyone else"), I added a question at the beginning of each session: "How strongly do you believe today that you're competent? When did you believe that most strongly this week? What was going on?"

Examining Advantages of the Adaptive Belief

I also helped Abe examine the advantages of seeing himself as competent. We identified several advantages: It would be more reality based, increase his self-confidence, make him feel better about himself, improve his mood, motivate him to try things that seemed difficult, and help him accomplish tasks.

Pointing Out the Meaning of Positive Data

Early in treatment, when we identified one of Abe's adaptive behaviors, I praised him and often characterized these actions as showing evidence of competence and other related qualities:

> "It's so good you helped your neighbor. I think it shows you have a lot of skills—plus I think it's another example of how competent you are—do you agree?"
> "It sounds like your grandson's soccer coach saw you as a real asset. Do you think that's right?"
> "Persevering like that, until you finished the forms, shows how hard working you are, doesn't it?"
> "Getting your apartment in order really indicates you're taking control; do you think so too?"

As therapy progressed, I elicited the meanings from Abe. "What does it say about you that you were so helpful at the homeless shelter?" "What does it say about you that Charlie wants you to keep working for him?"

Referencing Other People

One way to help clients get some distance from their beliefs is to ask them to think about how the adaptive belief might apply to other people or what others' perspective about them might be. Here are several ways to do that:

- Ask clients about people who historically viewed them in a favorable light: "Who in your life believed most strongly that you were competent? Why? Could this person have been right?"
- Ask them to think of a specific person and how they would evaluate this person in terms of the adaptive belief: "Abe, who is someone whom you view as competent in

most ways? What have *you* done this week that you would say shows that [this person] is competent if *he* or *she* had done it?"

- Ask them to reflect on whether they would discount positive evidence if they compared what they did to a hypothetical *negative* model: "Abe, you don't believe that paying all your bills is a sign of competence. But would a *truly* incompetent person have been able to do that?"
- Ask them to name another person who views them positively: "Abe, who's someone who knows you pretty well, whose judgment you trust? What would [this person] say you had done this week that's evidence you're competent?" or "Abe, what have you done this week that *I* would consider a sign of competence?"

Using a Chart to Collect Evidence

An important Action Plan item was for Abe to remind himself to look for data that supported his positive beliefs. Once we agreed to work on his belief that he was competent, we converted his "credit list" into an "Evidence of Competence Chart" (Figure 18.1). I made this chart in session for him. We started it together so I could be sure he understood what to do. I asked him to include evidence about things that not only were even a little difficult but also were easy but nevertheless indicated competence. The chart also elicited his conclusions about these experiences and, especially, what these experiences showed about him. He filled out the chart at home and brought it to therapy so he could add additional examples we discovered during our sessions. A little later in treatment, we used the same chart to collect historic evidence of competence.

Event/Experience	*Conclusion, or what this says about me*
I finished going through all the bills and paying them.	*I can concentrate better than I thought.*
Soccer coach thanked me several times again after the game.	*I can organize people pretty well.*
I helped Jim fix a leak.	*I can figure things out.*

FIGURE 18.1. Abe's Evidence of Competence Chart. He also took photographs of the pile of bills he had just finished paying, of the soccer coach and team, and of Jim's leaky pipe.

I asked Abe to take a photograph of as many of these positive experiences as he could (or to look online for an image that represented the experience) to show me at subsequent sessions. Reviewing the photographs gave me the chance to respond to his discounting cognitions; they were a potent reinforcer that his new core belief was accurate.

Inducing Images of Current and Historical Experiences

Imagery tends to reinforce adaptive beliefs at both the intellectual and the emotional level, especially when clients experience positive affect as they visualize a scene. I asked Abe to tell me about and then visualize both recent and historic memories. Here's one example:

JUDITH: Can you think about your history? What was a situation in which you felt really competent? … Can you imagine this scenario, as if it's happening right now? … Tell me what you see, what you're thinking, how you're feeling …

ABE: (*Visualizes and describes the experience of finding out he was getting a promotion at work.*)

JUDITH: You know, you're still the same person now, with the same level of competence. It's just partially covered over by the depression, which affects what you do, what you think, and how you feel.

Acting "As If"

Clients are often willing to act as if they believe their adaptive belief—and doing so strengthens this belief. Abe and I were discussing an upcoming job interview. I asked Abe to visualize this situation, as if it were happening right now, and to imagine acting as if he believed his positive belief. His Action Plan was then to act that way in the actual situation.

> "Abe, can you imagine what it would be like if you completely believed you were competent when you went for your job interview? Can you visualize it? … How do you feel when you enter the reception area? … What are you thinking? … Remember, you completely believe you're competent. When you walk up to the receptionist, what does your posture look like? … What does your

face look like? … What do you say to the receptionist? … How are you feeling? … What do you do when you meet the interviewer? … What do you look like sitting in the chair? … What do you say when he asks you about your previous job?"

CLINICAL TIPS

When clients have difficulty identifying positive data, you can use the metaphor of the screen from Chapter 17 to remind them that they may be missing or discounting positive evidence. Then discuss what they could do in the coming week to get better at this skill.

MODIFYING MALADAPTIVE BELIEFS

The degree of difficulty in modifying negative beliefs varies from client to client. In general, it's far easier to modify the negative beliefs of clients with acute disorders whose counterbalancing adaptive beliefs have been activated throughout much of their lives—as compared to clients with personality disorders (J. S. Beck, 2005; Beck et al., 2015; Young et al., 2003). The beliefs of some clients change easily, at least at the intellectual level, but the beliefs of others require considerable effort over time to change at both an intellectual and an emotional level.

Clients vary widely in the degree to which they're able to modify their core beliefs. It's not possible or realistic for some clients to reduce the strength of these beliefs to 0%. Generally, beliefs have been sufficiently weakened when clients are likely to continue modifying their dysfunctional behavior despite still holding on to a remnant of the belief.

Beliefs usually change at the intellectual level first, especially if you've been employing only intellectual-level techniques. Clients may need experiential techniques (including using imagery, doing role playing, using storytelling or metaphors, and engaging in behavioral experiments) to change their beliefs at the emotional level. Cognitions change in the presence of affect, so the best time to work on negative beliefs is when their schemas are activated in session. Clients then generally experience change at both levels as corrective information is received.

Gestalt-type techniques, such as empty-chair work (Pugh, 2019), can be quite useful in exposing clients to painful beliefs and emotions or

distressing interpersonal situations. Clients generally learn that they don't need to protect themselves from upsetting situations; they don't need to use coping behaviors, such as escape, avoidance, or distraction. Techniques using an extended metaphor of a trial are also helpful in helping clients identify and modify entrenched core beliefs (De Oliveira, 2018).

Techniques to Modify Negative Beliefs

To change a negative belief, you will educate clients about core beliefs, monitor the activation of their schemas, explain their contribution to clients' current difficulties, and motivate clients to change them (as described in Chapter 17). You'll use both intellectual- and emotional-level techniques, as described below. Many of the techniques are also used to modify automatic thoughts.

- Socratic questioning
- Reframing
- Behavioral experiments
- Stories, movies, and metaphors
- Cognitive continuum
- Using others as a reference point
- Self-disclosure
- Intellectual–emotional role plays
- Historical tests
- Restructuring the meaning of early memories

Socratic Questioning

When evaluating Abe's beliefs, I use the same kinds of questions as I used in evaluating his automatic thoughts. Even when I identify a general belief, I help Abe evaluate it in the context of specific situations. This specificity helps make the evaluation more concrete and meaningful, and less abstract and intellectual.

JUDITH: [summarizing what Abe learned from the just-completed downward arrow technique] Okay, so you believe about 90% that if

you ask for help, it means you're incompetent. Is that right?

ABE: Yes.

JUDITH: Could there be another way of viewing asking for help?

ABE: I'm not sure.

JUDITH: Take therapy, for example. Are you incompetent because you came for help here?

ABE: A little, maybe.

JUDITH: Hmm. That's interesting. I usually view it in the opposite way. Is it possible it's actually a sign of *strength* and *competence* that you came to therapy? Because what would have happened if you hadn't?

ABE: I'd probably be much worse.

JUDITH: Are you suggesting that asking for appropriate help when you have an illness like depression is a more competent thing to do than remaining depressed?

ABE: Yeah … I guess so.

JUDITH: Well, you tell me. Let's say we have two depressed people. One seeks treatment, works hard, and overcomes his depression. The other person refuses therapy and continues to have depressive symptoms. Whom do you consider more competent?

ABE: Well, the one who goes for help.

JUDITH: Now how about another situation you've mentioned, volunteering at the homeless shelter? Again, we have two people. They're not sure how to deal with an aggressive person because they've never had to do it before. One asks the staff what to do. The other doesn't and continues to struggle. Who's the more competent?

ABE: (*hesitantly*) The one who goes for help?

JUDITH: Are you sure?

ABE: (*Thinks for a moment*.) Yeah. It's not a sign of competence to just struggle if you could get help and do better.

JUDITH: How much do you believe that?

ABE: Pretty much.

JUDITH: And do these two situations—therapy and help at the shelter—apply to you?

ABE: I guess they do.

Here I used Socratic questioning in the context of two specific situations to help Abe evaluate his dysfunctional belief. I judged that the standard

questions of examining the evidence and evaluating outcomes would be less effective than asking leading questions. Note that when you're evaluating beliefs, you may need to ask questions that are more persuasive and less evenhanded than when evaluating more malleable cognitions at the automatic thought level.

Reframing

You can hand draw a chart to help clients track and reframe evidence that seems to support their dysfunctional beliefs (Figure 18.2).

Event/Experience	*Reframe*
Asking for help at homeless shelter	*Competent people ask for help when they need it.*
Going to therapy	*It's a sign of strength and competence to get treatment.*
Lost my job	*Boss changed my job and didn't provide training.*

FIGURE 18.2. Abe's Reframes of Competence Belief Chart.

JUDITH: [summarizing] So it was difficult for you to come to therapy and talk to a supervisor at the homeless shelter because of your belief "If I ask for help, it shows I'm incompetent or a failure." Is that right?
ABE: Yes.
JUDITH: Now that we've discussed it, how do you see it?
ABE: If I ask for help, I'm not incompetent?
JUDITH: You don't sound convinced. Let's see. Do you want to phrase it like this: "Asking for help when I need it is a sign of competence"?
ABE: Yes.
JUDITH: How much do you believe this new idea now?
ABE: A lot … (*Reads and ponders the new belief.*)
JUDITH: Would you be willing to keep a chart in which you write down evidence that you initially think supports the idea that you're incompetent?
ABE: Yes.
JUDITH: Then you can counter it with a more realistic perspective, which we can call the "alternative view" or "reframe" or something else.

What do you want to call it?

ABE: I like "reframe."

I then draw the chart in Figure 18.2. I ask Abe to think of another item that belongs on the chart, and he writes it down. He agrees to an Action Plan item to continue filling in the chart at home. I advise him that it may be difficult at first to think of a reframe but that we can fill in the right side of the chart together at subsequent sessions. I also ask him to keep this chart in front of him during our sessions, so he can add to it when the topic we're discussing is relevant to his negative core belief.

Next, I suggest an Action Plan to help reinforce the new, more adaptive belief. (You read about this acting "as if" technique earlier in this chapter.)

JUDITH: Also, could you be on the lookout for other situations this week where you *could* reasonably ask for help? That is, let's imagine that you believe the new belief 100%, that asking for reasonable help *is* a sign of competence. When during this coming week might you ask for help? Can you think of anything now?

ABE: Well, yesterday I tried to rewire a lamp, but I couldn't. I was going to keep trying … but I suppose I could ask my neighbor for help.

JUDITH: Perfect. If you can think of any other reasonable opportunities to ask for help, could you do that?

ABE: Okay.

JUDITH: And when you do ask, make sure to give yourself enormous credit —because you'll be doing something hard, something that goes against your grain but is really, really important.

Once you've introduced both the Evidence of [the Adaptive Belief] Chart and the Reframes of [the Negative Belief] Chart, you can consolidate them into the Belief Change Worksheet (Figure 18.3).

Event/experience that supports my new belief "*I am competent*." What does this say about me?	Event/experience with reframes of my old belief "*I am incompetent*."

Event/experience that supports my new belief "*I am competent*." What does this say about me?	Event/experience with reframes of my old belief "*I am incompetent*."
• *Figured out how to work [son's] drone, which shows I'm competent.* • *Fixed bookshelf for daughter when my son-in-law couldn't—evidence of competence.* • *Balanced checkbook—most people can do this, but it's still a sign of competence.* • *Helped put up drywall for Charlie—I was competent.*	• *Had trouble understanding article on economic trends, but most people probably would.* • *Couldn't figure out how to fix the brakes in my car, but I'm not a trained mechanic.* • *Got a parking ticket, but the sign was ambiguous.* • *Dinner I made tasted terrible, but that means I'm incompetent at cooking that meal, not that I'm incompetent as a person.*

FIGURE 18.3. Abe's Belief Change Worksheet. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

Behavioral Experiments

As with automatic thoughts, you can help clients devise behavioral tests to evaluate the validity of a belief. Behavioral experiments, when properly designed and carried out, can modify a client's beliefs more powerfully than verbal techniques, at both the emotional and the intellectual level.

JUDITH: [summarizing] It sounds as if this belief, "If I ask others for help, they'll be critical of me," got in the way this week?
ABE: Yeah, that's why I didn't ask my neighbor.
JUDITH: How much do you believe that?
ABE: I don't know—a lot.
JUDITH: Well, you came to me for help, and *I* haven't actually criticized you, have I?
ABE: No, of course not. But that's your job, to help people.
JUDITH: True, but it would be useful to find out if other people, in general, are more like me or not. How could you find out?
ABE: I'd have to ask them for help.

In the next part, I find out whether asking his neighbor for help would be a good behavioral experiment.

JUDITH: Okay, can we talk about your neighbor? What evidence do you have that he'd be critical of you if you ask for help to wire the lamp?
ABE: (*Thinks.*) Well, he's a nice guy. I guess he wouldn't criticize me.
JUDITH: Has he helped you before?
ABE: You know, I almost forgot about this. But yeah, there was one time when my grandson brought his dog over and the dog ran away. My neighbor helped us look for him, and he was actually the one who found him.
JUDITH: Did he seem to be critical?
ABE: No, he seemed happy to help.
JUDITH: Then he might not criticize you now either?
ABE: No, no, I guess he wouldn't. I don't know why I didn't think of that.
JUDITH: Well, I think your depression is still affecting you.
ABE: I think I'll go knock on his door after dinner tonight.
JUDITH: Good. We can add that to your Action Plan. (*pause*)

Next, we discuss how Abe could cope if it turned out his neighbor was critical. Then I ask, "Now, is there anything else you've avoided asking for help with—because you thought you might be criticized?"

It's very important that clients change their behavior by decreasing their avoidance and entering into situations they've been avoiding. Otherwise, they won't have the actual experience of having their beliefs disconfirmed. For an extensive description and discussion of behavioral experiments, see Bennett-Levy and colleagues (2004).

Using Stories, Movies, and Metaphors

You can help clients develop a different idea about themselves by encouraging them to reflect on their view of characters or people who share the same negative core belief that they themselves have. When clients experience vivid examples of how others' very strong beliefs are invalid, or mostly invalid, they begin to understand how they too could have a powerful core belief that isn't accurate.

Maria was sure she was bad because her mother had been physically and emotionally abusive to her, often telling Maria how bad she was. It was helpful for Maria to reflect on the story of Cinderella, in which a

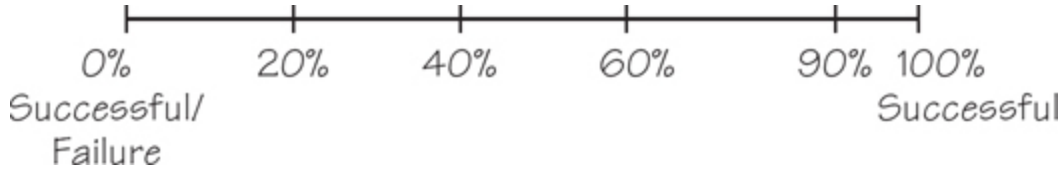
wicked stepmother treats a youth quite badly without the youth's being at fault.

For additional common metaphors used in CBT, see Stott and colleagues (2010) and De Oliveira (2018).

Cognitive Continuum

This technique is useful to modify both automatic thoughts and beliefs that reflect polarized thinking, that is, when the client sees something in all-or-nothing terms. A cognitive continuum helped Abe see that there's a middle ground between being a success and a failure.

JUDITH: [summarizing] So when you found out that you had bounced a check, you thought, "I'm a failure." Can we see how that looks on a scale? (*Draws a number line.*) So 100%—that would represent someone who's a complete success. And 0%—that's someone who's 0% successful, in other words, a failure. (*pause*) Now, where on this scale do you belong?



ABE: Well, I'm almost out of money, and I don't have a real job. I'm at 0.
JUDITH: Though you do volunteer—even though you're depressed. And you are *looking* for work, right?
ABE: I guess so. Maybe I'm 20%.
JUDITH: Is there anyone else who's between you and someone who isn't working at all?
ABE: Umm … Maybe this guy, I know. Jeremy. He works as little as he possibly can. He'd much rather just sit back and collect unemployment.
JUDITH: Okay. Where does Jeremy go?
ABE: About 20%.
JUDITH: And you?
ABE: About 30%. At least I'm *trying* to get a job.

JUDITH: And when you did work, what was *your* work ethic like?
ABE: Oh, I always worked hard.
JUDITH: Let's take a look at another guy who never works. Let's say he keeps borrowing money from family members. He could work, but he never wants to, so he never does. Is this the kind of guy who's at zero?
ABE: Probably.
JUDITH: Now, how about a person who never works, lives off his family's money, and actually does harm to others.
ABE: That person would be a worse failure.
JUDITH: So if he's 0%, where is the guy with family money who isn't hurting anyone?
ABE: (*Thinks.*) Oh, I guess 20%. He's not a failure in every way.
JUDITH: And Jeremy and you?
ABE: Let's see. He'd be 40%, and I'd be … I'm not sure.
JUDITH: Well, if you were working now, where would you be?
ABE: Hmm. Maybe 90%? Because I don't think I could ever be 100% successful.
JUDITH: So does that put you now between 40% and 90%?
ABE: (*sounding unconvinced*) I guess so …
JUDITH: Let me ask you this: Why don't you have a paid job? Is it because you're just lazy or because you have a bad work ethic? Or is it because the depression has been affecting you?
ABE: It's the depression.
JUDITH: Are you sure?
ABE: Well, I know I'm not lazy when I'm not depressed, and I do have a good work ethic—and I'm looking for a job now … So I guess I'd be at 60%.
JUDITH: How accurate is it to call someone a failure—0% successful—who is at the 60% mark?
ABE: Not very.
JUDITH: Maybe the *worst* thing you can say is that he or she is 60% successful.
ABE: Yeah. (*Brightens visibly.*)
JUDITH: And once you've been in a new paid job for say 6 months, where do you think you'll be?
ABE: It depends on the job, but I hope I'll be 90% successful.

JUDITH: Let me ask you another question: What has been the effect of labeling yourself as a failure?
ABE: It makes me feel more depressed.
JUDITH: Yes. And according to your own scale, it's not even true. So can you put in your own words what you've learned from this scale?
ABE: That I'm not a failure. I guess at worst, I'm a 60% success and I'm working my way back to being a 90% success.
JUDITH: That's excellent. Let's get that down in writing. And I'd like you to look at this scale every morning and whenever you start feeling like a failure again.

As with many of these belief modification techniques, you will probably find that clients change their thinking at both an emotional and an intellectual level if their negative emotions are heightened in the session. If their distress is low, you may get some change, but it will probably be only at the intellectual level. And you can directly teach clients how to use this kind of technique themselves between sessions.

> "Abe, let's review what we did here. We identified an all-or-nothing error in your thinking. Then we drew a number line to see whether there were really only two categories—success and failure—or whether it's more accurate to consider *degrees* of success. Can you think of anything else that you see in only two categories, something that distresses you?"

Using Other People as a Reference Point

When clients consider *other* people's circumstances and beliefs, they often obtain psychological distance from their own dysfunctional beliefs. They begin to see an inconsistency between what they believe is true or right for themselves and what they more objectively believe is true about other people.

In this first example, Abe disagrees with his cousin's core belief, and I help him apply this perspective to himself.

JUDITH: Abe, you mentioned last week that you think one of your cousins is depressed too?

ABE: Yeah. She called me last week. She's had a lot of trouble. First, she got fired from her job. Then her boyfriend broke up with her, and she had to move in with my aunt.

JUDITH: How do you think she sees herself?

ABE: When she called the other night, she said she feels like a failure.

JUDITH: What did you say to her?

ABE: That she's not a failure. That she's just going through a hard time right now.

JUDITH: Could that be true for you too?

ABE: (*Thinks.*) I'm not sure.

JUDITH: Is there something different about your cousin that makes her okay if she's depressed and doesn't have a job, but not you?

ABE: (*Thinks for a moment.*) No. I guess not. I hadn't really thought of it that way.

JUDITH: Do you want to write something down about this?

Finally, many clients can get distance from a belief by using a child as a reference point, someone they feel compassion for. This may be their own child or grandchild or another child they feel close to. Or they can imagine that they themselves have a child.

JUDITH: Abe, so you believe that if you don't do as well as everyone else, then you've failed?

ABE: Yeah.

JUDITH: I wonder, can you imagine that your granddaughter is now grown up? She's 50 years old and she's very upset because she's just lost her job. Would you want her to believe that she's a failure?

ABE: No, of course not.
JUDITH: Why not? … What would you like her to believe? (*Abe responds.*) Now how does what you've just said apply to you?

Using Self-Disclosure

Using appropriate and judicious self-disclosure can help some clients view their problems or beliefs in a different way. The self-disclosure, of course, needs to be genuine and relevant:

JUDITH: You know, Abe, when I started working full time, I was overloaded. And so was my husband. But I was hesitant to ask anyone for help at home. I thought I should be able to manage on my own. Ultimately, I did get someone to help me. What do you think it meant about me that I needed help? Did it mean I was incompetent?
ABE: No, not at all. You probably *did* have too much to do.
JUDITH: So, someone can need help but not be incompetent?
ABE: I see what you mean.
JUDITH: Can you spell it out?
ABE: Maybe the fact that I need help now doesn't necessarily mean I'm incompetent.
JUDITH: What could it mean?
ABE: Like we talked about last week. That I'm depressed. That I wouldn't judge myself so harshly if I were on crutches and needed help.

Intellectual–Emotional Role Plays

This technique, also called "point–counterpoint" (Young, 1999), is usually employed after you have tried other techniques, such as those described in this chapter. It's particularly useful when clients say that *intellectually* they can see a belief is dysfunctional but that *emotionally* or in their gut it still "feels" true. You first provide a rationale for asking clients to play the "emotional" part of their mind that strongly endorses the dysfunctional belief, while you play the "intellectual" part. Then you switch roles. Note in both segments you and clients both speak as the client; that is, you both use the word "I."

JUDITH: It sounds from what you're saying that you still believe to some extent that you're incompetent.

ABE: Yeah.

JUDITH: I'd like to get a better sense of what evidence you still have that supports your belief, if that's okay.

ABE: Sure.

JUDITH: Can we do a role play? I'll play the "intellectual" part of your mind that intellectually knows you're not incompetent *through* and through. I'd like *you* to play the *emotional* part of your mind, that voice from your gut that still believes you *are* incompetent. I want you to argue against me as hard as you can, so I can really see what's maintaining the belief. Okay?

ABE: Yeah.

JUDITH: Okay, you start. Say "I'm incompetent because …"

ABE: I'm incompetent because I lost my job.

JUDITH: No, I'm not. I have a *belief* that I'm incompetent, but I am reasonably competent most of the time.

ABE: No, I'm not. If I were truly competent, I would have done really well in the job.

JUDITH: That's not true. I didn't do well on the job because my boss changed my responsibilities and didn't train me well enough.

ABE: Well, Emilio had done well in inventory. That shows I was incompetent.

JUDITH: That's not right either. Emilio had strengths in the skills needed for inventory, and I had other strengths. The worst thing you can say is that I was incompetent in doing inventory. But I am competent in lots of other things.

ABE: But I haven't been acting very competently in the last year or two.

JUDITH: That's true; though as my depression has gotten better, I've been acting a lot more competently recently.

ABE: But a truly competent person wouldn't become depressed in the first place.

JUDITH: Actually, even truly competent people get depressed. There isn't a connection between those two things. And when truly competent people get depressed, their concentration and motivation definitely suffer, and they don't perform as well as usual. But that doesn't mean they're incompetent through and through.

ABE: I guess that's true. They're just depressed.
JUDITH: You're right, but you're out of role. Any more evidence that you're completely incompetent?
ABE: (*Thinks for a moment.*) No, I guess not.
JUDITH: Well, how about if we trade roles now, and this time you be the "intellectual" part who responds back to my "emotional" part? And I'll use your same arguments.
ABE: Okay.
JUDITH: I'll start. "I'm incompetent because I because I lost my job."

Switching roles provides clients with an opportunity to speak with the intellectual voice that you've just modeled. You use the same emotional reasoning and the same words that they used. Using their own words and not introducing new material help clients to respond more precisely to their specific concerns.

CLINICAL TIPS

If clients are unable to formulate a response while in the intellectual role, you can either switch roles temporarily or come out of role to discuss the stuck point. As with any belief modification technique, you will evaluate both its effectiveness and the degree to which clients need further work on the belief. You do so by asking clients to rate how strong their belief is before and after the intervention.

Many clients find the intellectual–emotional role play useful. A few, however, feel uncomfortable doing it. As with any intervention, the decision to use it should be collaborative. Because it is a slightly confrontational technique, take special note of clients' nonverbal reactions during the role play. Also take care to ensure that clients do not feel criticized or denigrated by the elevation of the intellectual part of their mind over the emotional part.

Historical Tests

Modifying dysfunctional beliefs by reframing relevant current experience or using current material as examples is sufficient for many clients. Others benefit from discussing how and when a negative core belief originated

and became maintained and why it made sense for the client to believe it at the time.

Maria's belief that she was unlikeable stemmed from childhood. I asked her, "What memories do you have in which you believed you were unlikeable? Let's start with your elementary school years, so when you were about 6 to 11." Next, I asked her for relevant memories when she was an adolescent. (She didn't have any pertinent memories as a very young child.) Then we used Socratic questioning to reframe the meaning she put to each of these experiences. Finally, I asked Maria to record a summary of her new understanding of herself from the most salient time periods. Here's what she concluded about elementary school: "I was basically likeable. I had a best friend, and I was friendly with some other girls. I was bullied by a group of kids who picked on people to make themselves feel superior. That says something negative about them but not about me." I asked Maria to read this therapy note every day.

Restructuring the Meaning of Early Memories

To modify the meaning of significantly negative events (from childhood or later) at the emotional level, some clients may also need experiential techniques in which they "relive" the experiences in session with you and, in the presence of significant affect, use role play or imagery to reframe the meaning at the emotional level. (See Appendix D.)

SUMMARY

Strengthening adaptive beliefs and restructuring maladaptive beliefs require consistent, systematic work over time. Techniques applicable to restructuring automatic thoughts and intermediate beliefs may be used along with more specialized techniques oriented specifically toward core beliefs. Additional strategies to modify core beliefs can be found in multiple sources, including J. S. Beck (2005), Beck and colleagues (2015), McEvoy and colleagues (2018), Pugh (2019), and Young (1999).

REFLECTION QUESTIONS

How can you strengthen adaptive beliefs and modify maladaptive beliefs? How do beliefs become strengthened over time?

PRACTICE EXERCISE

Imagine that you have a core belief that you are inferior, unlovable, or worthless. Think of a corresponding adaptive core belief and fill out the Belief Change Worksheet.

19

ADDITIONAL TECHNIQUES

We've already covered many basic CBT techniques in this book, among them, psychoeducation, focusing on aspirations, values, and strengths; monitoring mood and behavior; cognitive restructuring; worksheets; behavioral experiments; and mindfulness. These techniques may influence clients' thinking, behavior, and/or physiological arousal, in addition to their mood. Some increase positive affect, some decrease negative affect, and some do both. As described in Chapter 9, you collaboratively choose techniques using your conceptualization of the client as a guide.

As described in Chapter 2, CBT adapts techniques from many evidence-based psychotherapeutic modalities: acceptance and commitment therapy, compassion-focused therapy, dialectical behavior therapy, emotion-focused therapy, Gestalt therapy, interpersonal psychotherapy, meta-cognitive therapy, mindfulness-based cognitive therapy, motivational interviewing, psychodynamic psychotherapy, schema therapy, solution-focused brief therapy, well-being therapy, and others, within the context of a cognitive conceptualization. You will also invent your own techniques as you become more proficient as a CBT therapist.

This chapter answers the following questions:

- How do you help clients regulate their emotions (e.g., through refocusing, distraction, self-soothing, and relaxation exercises)?
- How do you know when to do skills training?
- How do you help clients become better problem solvers?
- How do you help clients make decisions?

How do you create graded task assignments?

How do you do exposure?

When might you use role playing?

When are “pie” techniques useful?

How can you change unfavorable self-comparisons?

EMOTION REGULATION TECHNIQUES

The goal of CBT is not to eliminate negative emotion. All emotions are important. Negative emotions frequently point to a problem that needs to be solved (which may or may not include changing one’s thinking)—or, if it can’t be solved, accepted. The goal of CBT is to reduce the degree and duration of negative emotion that doesn’t seem to be proportionate to the situation (given the client’s culture and circumstances), usually related to distorted or unhelpful perceptions. Acceptance of negative emotion (instead of avoidance) is key for some clients (Linehan, 2015; Segal et al., 2018). Acceptance and commitment therapy (Hayes et al., 1999) describes useful metaphors for accepting negative emotion and turning one’s attention to valued action.

You’ve read about emotion regulation techniques throughout this book, especially modifying dysfunctional cognitions and maladaptive behavior; engaging mindfully in social, pleasurable, productive, and self-care activities; exercising; focusing on one’s strengths and positive qualities; and cultivating positive cognitions and adaptive behavior. Below are some additional techniques.

Refocusing, Engaging in Valued Behavior, and Self-Soothing

Most of the time when I feel distressed, I check the accuracy of my thinking and do problem solving. But occasionally I get stuck thinking in an unhelpful way. For example, this sometimes happens to me when I have a problem I can’t fix, at least at the moment, or when I’m feeling irritated by something I can’t change. If examining my thinking doesn’t help, I

change my focus. I tell myself, “Thinking about this right now isn’t helpful. It’s okay that I’m feeling _____ (nervous, irritated, etc.). I should just refocus on what I’m doing (or engage in a valued action).” I assume you do this too, and you can teach your clients to do the same. Help them monitor their negative affective responses, noticing where their attention is, and then shift their focus to something else.

Multiple websites list pleasant, self-soothing activities, relaxation, or mindfulness exercises. To name just a few, clients can refocus on the task at hand, their immediate experience (using all their senses, especially if they’re ruminating about past events or obsessing about future events), their bodies or their breath, or their aspirations and a plan to work toward those aspirations. They can engage in various activities: valued action, talking to other people, surfing the net, playing a video game, posting or viewing posts on social media, doing chores, exercising, taking a bath or shower, interacting with children or pets, or practicing gratitude.

Abe often ruminated and became quite self-critical about perceived mistakes he had made in the past, and he worried about finances and his future. I taught him mindfulness of the breath and helped him compose a written list of things he could do to engage his attention elsewhere since we determined that rumination and self-criticism caused more harm than good.

Relaxation

Many clients, especially those who experience bodily tension, benefit from learning relaxation techniques, described in detail elsewhere (Benson, 1975; Davis et al., 2008; Jacobson, 1974). There are several kinds of relaxation exercises, including progressive muscle relaxation (PMR), imagery, and slow and/or deep breathing. PMR teaches clients to alternately tense and then relax muscle groups in a systematic way. Imagery involves having clients create a vision in their minds of feeling relaxed, calm, and safe in a particular environment, such as lying on a beach. There are several breathing exercises you can teach clients too. Search online for scripts, and have clients try one or more of these exercises in session, while you make an audio recording on the client’s phone, followed by daily home practice.

CLINICAL TIPS

Some clients experience a paradoxical arousal effect from relaxation exercises; they actually become more tense and anxious (Barlow, 2002; Clark, 1989). You can use this as a learning experience. Ask clients, "What are you most afraid could happen if you continue with this exercise?" Then encourage them to continue the relaxation techniques to find out to what degree, if at all, their fears come true.

SKILLS TRAINING

Many depressed clients show deficits in certain skills, including communication, effective parenting, job interviewing, budgeting, household or time management, organization, and relationships. When you uncover a skill deficit, give a rationale for working on it and then make a collaborative decision to do so. Describe the skill and demonstrate it during the session. CBT self-help books and workbooks can also be useful in teaching clients some skills; you can find a list at *www.abct.org/SHBooks*.

When you uncover an obstacle or problem, however, you'll need to see whether clients have an actual skill deficit or whether they have cognitions that interfere with their using a skill they already possess. You can ask them, "If you were sure that you'd get a good outcome, then what would you do or say?" If they give you a reasonable response, they may not need skills training, just cognitive restructuring. For example, the thought "What if I make a mistake?" might lead clients to avoid doing a task they know how to do. "If I put limits on my child, he won't listen to me anyway" might lead to overly permissive parenting. Yet these clients may have adequate skills.

CLINICAL TIPS

When clients are unsure about what to say to another person, give them the choice of whether to play themselves or the other person in a role play. If they play themselves, and do a good job, give them positive feedback and ask them if they want to record what they said, to remember it better. If they don't do a good job, ask them if they'd like you to demonstrate another approach. If so, you'll play the client but then switch roles so the client gets a chance to practice. If needed, interrupt the role play to give feedback and have the client practice again. Collaboratively set an Action Plan to use the communication skill in particular circumstances or with specific people.

PROBLEM SOLVING

Associated with or in addition to their psychological disorders, clients face real-life obstacles to taking steps toward valued action or fulfilling their aspirations. At every session, you'll encourage clients to look ahead to the coming week or weeks, think about what they can do to improve their experience, and identify potential obstacles or problems. There are several approaches you can take, depending on the nature of the predicted difficulties.

Difficulty Solving Problems

You can focus on encouraging clients to devise solutions to the problem, in accordance with their values and aspirations. When clients are deficient in problem-solving skills, they may benefit from direct instruction in problem solving, where they learn to specify a problem, devise solutions, select a solution, implement it, and evaluate its effectiveness (see, e.g., D'Zurilla & Nezu, 2006). You can also ask clients how they've solved similar problems in the past, or how they might advise a close friend or family member to solve the same kind of problem. Or you can offer potential solutions yourself. You can also use judicious self-disclosure, when relevant.

Some problems are facilitated by a change in the environment. Maria realized that her overconsumption of high-calorie junk food was related to not having enough healthy food around. She decided to make it a priority to go to the supermarket twice a week. This change helped significantly.

Some problem solving may involve significant life changes. After careful evaluation of a situation, you might encourage battered spouses to seek refuge or take legal action. If you have clients who are chronically dissatisfied with their jobs, you might guide them in analyzing the advantages and disadvantages of staying in their current job versus looking for another job.

When dysfunctional cognitions interfere with problem solving, you'll help clients identify and respond to interfering cognitions and then return to problem solving. Abe, for example, wanted to buy clothes for a special event. He knew how to ask his cousin to go with him, but his belief that he

shouldn't ask for help inhibited him. After evaluating his cognitions about this specific situation, Abe implemented the solution he himself had initially conceived.

When Problems Can't Be Solved

Not all problems, of course, can be solved. When problems aren't leading to much distress, clients may be able to accept them without much help from you. You might teach them the "Oh, well" technique (J. S. Beck, 2007). "Oh, well" is shorthand for "I don't like this situation or problem. But there's nothing I can do to change it, not if I want to reach my goal. So, I might as well stop struggling, accept it, and change my attention to something else." Abe found this technique useful when he didn't get a job he had interviewed for.

When clients have unhelpful cognitions associated with an unsolvable problem, cognitive restructuring is often called for (see pp. 258–259). Abe had a problem with his ex-wife. She was highly critical of him. He had tried to talk to her several times about having more productive conversations, but she just criticized him more. It seemed unlikely that she would change. What made the problem worse though were Abe's cognitions when he was depressed. He often thought, "She's right. I am good for nothing." Evaluating and responding to that cognition made it easier for Abe to accept her behavior, to turn his attention elsewhere, and to work toward increasing life satisfaction in other ways. Although he couldn't fix the problem, he was able to change his *response* to the problem.

When Problems Have a Low Probability of Occurrence

When problems are unlikely to occur, you might help clients

- assess the probability that the problem will occur,
- look for best and most realistic outcomes,
- discuss how to cope if the problem does arise,
- distinguish between reasonable and unreasonable precautions,
- accept uncertainty,
- decrease an overinflated sense of responsibility,
- recognize and expand their personal and external resources, and/or

- increase their sense of self-efficacy.

MAKING DECISIONS

Many clients, especially those who are depressed, have difficulty making decisions. When clients want your help in this area, ask them to list the advantages and disadvantages of each option and then help them devise a system for weighing each item and drawing a conclusion about which option seems best (see Figure 19.1).

Advantages of Volunteering	*Disadvantages of Volunteering*
1. *Get me out of the apartment* 2. *Make me feel useful, productive* 3. *Help people* 4. *Good step before I get a paying job* 5. *Learn new skills?*	1. *Might be too tired* 2. *Might not like it* 3. *Thinking about it makes me anxious*
Advantages of Not Volunteering	*Disadvantages of Not Volunteering*
1. *Don't have to feel anxious about it* 2. *Can save my energy for other things* 3. *Don't have to face potential failure*	1. *Doesn't help my depression* 2. *Doesn't get me out of the house* 3. *Doesn't give me potential opportunity to feel useful and productive* 4. *Doesn't help me practice for a paying job* 5. *Doesn't increase my skill set*

FIGURE 19.1. Abe's advantages–disadvantages analysis.

JUDITH: You mentioned that you wanted help in deciding whether to volunteer at the homeless shelter?

ABE: Yes.

JUDITH: Okay. (*Pulls out a piece of paper.*) If it's okay, I'd like to show you how to weigh advantages and disadvantages. Have you ever done that?

ABE: No. At least not in writing. I've been going over some of the pros and cons in my head.

JUDITH: Good. That'll help us get started. I think you'll find that writing them down will make the decision clearer. Which one do you want to start with, volunteering or not volunteering?

ABE: Volunteering, I guess.

JUDITH: Okay. Write "Advantages of Volunteering" at the top left of this paper and "Disadvantages of Volunteering" on the top right, and "Advantages of Not Volunteering" and "Disadvantages of Not Volunteering" at the bottom.

ABE: (*Does so*.) Okay.

JUDITH: What have you been thinking? Could you jot down some advantages and disadvantages of volunteering there? (*Abe writes down the ideas he has had so far. I ask some questions to guide him.*) How about the fact that you'd be getting out of your apartment—is that an advantage too?

ABE: Yeah. (*Writes it down.*)

Abe and I continue this process until he feels he has recorded both sides fairly and thoroughly. We repeat the process with the second option. Examining advantages and disadvantages of one option reminds Abe of additional items to add to the other option. Next, I help Abe evaluate the items:

JUDITH: Okay, this looks pretty complete. Now you need to weigh the items in some way. Do you want to circle the most important items—or rate the importance of each one on a 1–10 scale?

ABE: Circle the items, I guess.

JUDITH: Okay, let's look at each list now. Which items feel the most important to you? (*Abe circles items in each column in Figure 19.1*.) Just looking over what you've circled, what do you think?

ABE: I'd like to volunteer because I'd be helping people and I think I'd feel productive, and it would be good to get out. But I don't think I'd know what to do.

JUDITH: Do you think everyone who volunteers there knows what to do beforehand? Can you find out if there's an orientation? And who is the person you should find if you have questions? Maybe you need a little more information before you make the decision.

At the end of the discussion, I increase the probability that Abe will use this technique again:

> "Did you find this [process of listing and weighing advantages and disadvantages] useful? Can you think of any other decisions you might have to make where it would be good to do the same thing? How can you remember to do it this way?"

GRADED TASK ASSIGNMENTS AND THE STAIRCASE ANALOGY

Depressed clients get easily overwhelmed by tasks they need to accomplish. It's important to break down larger tasks into manageable parts (Beck et al., 1979). To reach a goal, you usually need to accomplish a number of tasks or take a number of steps along the way. Clients tend to become overwhelmed when they focus on how far they are from a goal, instead of focusing on their current step. A graphic depiction of the steps is often reassuring (Figure 19.2).

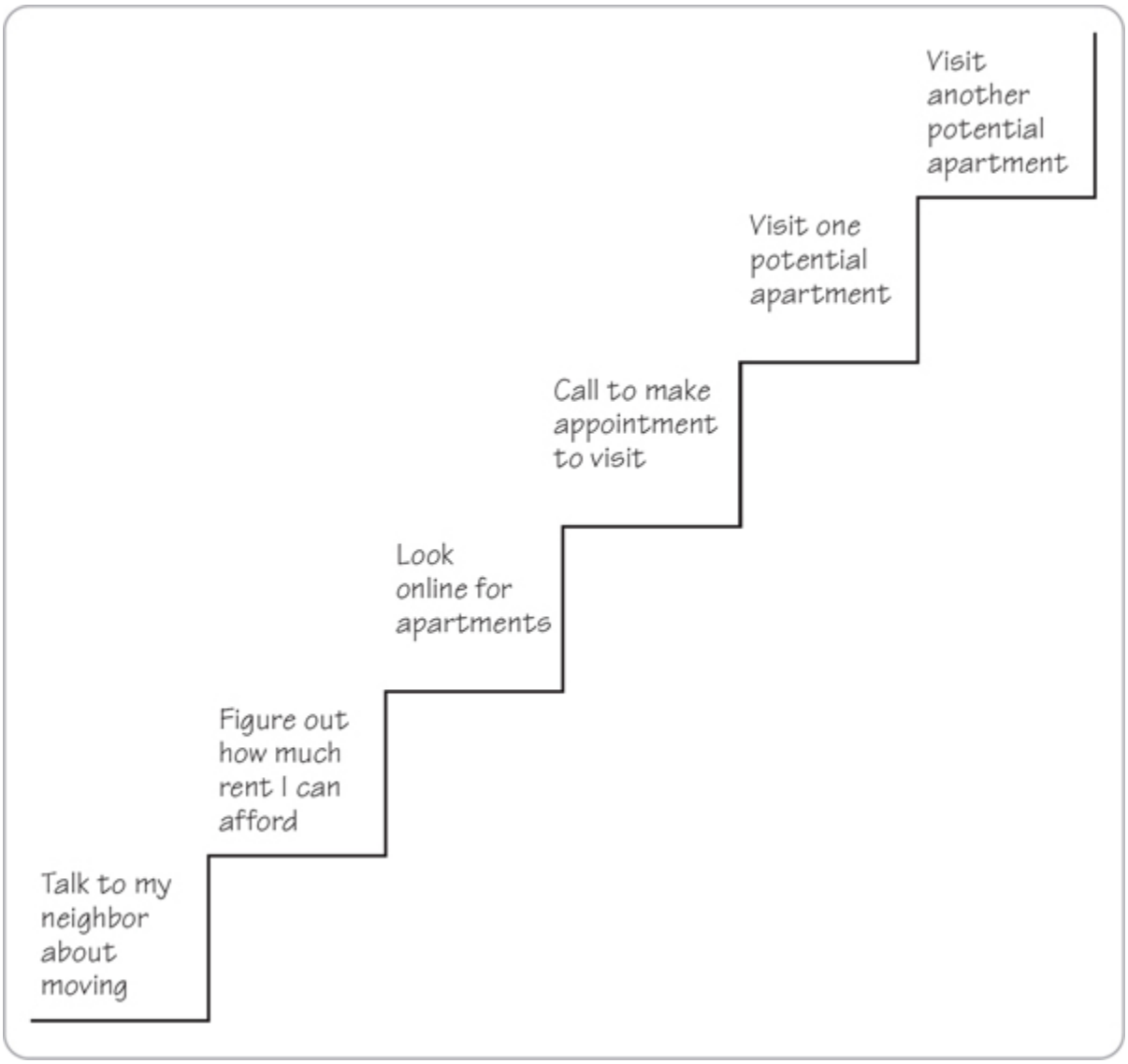

Visit another potential apartment
Visit one potential apartment
Call to make appointment to visit
Look online for apartments
Figure out how much rent I can afford
Talk to my neighbor about moving

FIGURE 19.2. Using a staircase metaphor.

JUDITH: Maria, it sounds like you get nervous just thinking about moving, though it's something you really want to do.

MARIA: Yeah.

JUDITH: I wonder how we could break it down into steps; for example, could you start by deciding which neighborhoods you might want to move to?

MARIA: Yeah. I was thinking of asking my new neighbor for advice. She did a lot of investigating before she moved next door.

JUDITH: What could the next step be? (*Guides Maria in identifying several additional steps.*) Are you still anxious about moving?

MARIA: Yeah, some.

JUDITH: (*Draws a staircase.*) Okay, here's what I want you to remember. You're going to go step by step, like going up a staircase. You're not going to move right away. You'll start here (*pointing to the bottom*), talking to your neighbor. Then you'll figure out how much you can afford in rent. Then you'll start looking online for apartments. Then you can make an appointment to visit the first apartment. Then you'll visit the first potential apartment. And then the second one. You'll start here (*pointing to bottom step*) and just move up one step at a time (*drawing arrow from bottom step to next step*). You'll feel more comfortable at each step before you take another one. You *won't* jump from here (*pointing to bottom step*) all the way up to here (*pointing to the top step*). Okay?

MARIA: Uh-huh.

JUDITH: So every time you start thinking about the final goal, how about reminding yourself of this staircase, especially of the step you're now on, and how you're going to take just one step at a time. Do you think that'll help bring down the anxiety?

EXPOSURE

Depressed and anxious clients often engage in avoidance, a coping strategy. They may feel hopeless about engaging in certain activities ("It won't do any good to call my friends. They won't want to see me") or fearful ("If I [do this activity], something bad will happen"). The avoidance may be quite apparent (e.g., clients who spend a great deal of time in bed, avoiding self-care activities, household tasks, socializing, and errands). Or the avoidance may be more subtle (e.g., socially anxious clients who avoid making eye contact, smiling at others, making small talk, and volunteering their opinions). These latter avoidances are *safety behaviors* (Salkovskis, 1996). Clients believe that these behaviors will ward off anxiety or feared outcomes.

While avoidance tends to bring immediate relief (and so is quite reinforcing), it perpetuates the problem. Clients don't get the opportunity to test their automatic thoughts and receive disconfirmatory evidence. When clients are anxious and significantly avoidant, you'll provide a strong rationale for exposure. Here's what you'd say using a traditional CBT approach:

THERAPIST: Can we talk now about decreasing your avoidance of _____ [the feared situation]? Research has shown us that the way to get over a fear of _____ is to expose yourself to it, either in gradual steps or all at once, whichever you'd like to do. For example, I know you have cats, so you must not have a fear of them. But if you did, how would you get over it? We could start by having you look at pictures or videos of cats and do that until you realized your predictions weren't accurate, and it's likely that your anxiety would decrease. (*pause*) Do you follow me so far?

CLIENT: Yes.

THERAPIST: Then maybe you'd visit someone you know who has a cat and is willing to put it in a carrier bag. Then maybe we'd have you get close to a kitten and work up to petting it, and so on. The idea is to reduce avoidance so you can learn whether your beliefs and predictions about cats are accurate. And you can also learn if you're able to tolerate anxiety.

As noted above, you'll create a hierarchy of avoided situations with clients. Have them rate how anxious they believe they would be in each situation, 0–100 (or 0–10), and write down the list, with the less anxiety-provoking activities first; and the most, last. Then find out which activity clients want to work on in the coming week. Clients usually want to start with less anxiety-provoking exposures. We usually look for situations in which they predict they'll be about 30% anxious. But occasionally a client chooses to engage in the most anxiety-provoking activity. When they successfully expose themselves to this situation, it usually speeds up treatment.

In a recovery orientation, you would link exposures to the client's values and aspirations. Here's what you might say:

> "I know it's important to you to be able to visit your grandmother, but it sounds like your coping strategy of avoidance is getting in the way. Do you want to take a step toward taking long car rides this week? You could go somewhere that you think will raise your anxiety only a little or you can really go for it and choose a place that could lead to much more anxiety."

Whether you formally or informally identify an exposure, ask clients to engage in the activity every day (if feasible) and stay in the situation until they find out that the feared outcome doesn't happen (Craske et al., 2014). We want clients to believe, "This activity isn't dangerous. I don't need to avoid it. Even if there's a bad outcome, I can still handle it." If at all possible, have clients engage in an exposure right in your office or accompany them to another place.

It's important for you and clients to be alert for their use of safety behaviors. We don't want them to think, "It's good I [used that safety behavior] or something bad really might have happened." Suggest that they ask themselves during exposures, "Am I doing anything to try to avert [the feared consequence] or to make [the feared outcome] less likely?" Also ask them to monitor their automatic thoughts *after* each exposure. They need to be alert for unhelpful cognitions such as "I was able to tolerate the anxiety this time but next time, I won't be able to." At the following session, if clients have successfully exposed themselves to the activity and drawn helpful conclusions, they can choose a new exposure for the coming week.

Imaginal exposure is often helpful. You can ask clients to imagine entering a situation or engaging in an activity, especially in two conditions:

1. When clients are too fearful to do even mild exposures.
2. When it's impractical to do regular exposures.

You can also have clients do virtual reality exposures in which they enter a "virtual" scenario to test their fears.

Clients are more likely to do daily work on a graded exposure hierarchy if you ask them to fill out a daily monitor (Figure 19.3). It can be simple, listing just the date, activity, and level of anxiety. You can also ask clients

to record and then *cross off* predictions that didn't come true, which further reminds them of the inaccuracy of many of their thoughts.

Date	Activity	Predicted level of anxiety (1–100)	Actual level of anxiety (1–100)	Predictions
12/12	*Going to church services*	*90%*	*60%*	~~*I won't be able to stand the anxiety.*~~ ~~*I'll have to leave services early.*~~

FIGURE 19.3. Exposure monitor.

Clients may also fear, and then avoid, internal stimuli:

- Experiencing strong emotion
- Thinking about upsetting or feared situations
- Having painful memories
- Becoming physiologically aroused
- Facing physical pain

These clients usually benefit from mindfulness exercises (see Chapter 16) in which they do behavioral experiments to expose themselves to these stimuli and test their fears.

CLINICAL TIPS

When clients are quite fearful of doing exposures, you may need to allow them to use safety behaviors at first, for example, having someone in the car with them when they drive across a bridge. But the next step should be entering the situation without using the safety behavior.

I've given you a broad outline of exposure, but you'll need additional instruction. Detailed descriptions of the process used to develop agoraphobic hierarchies can be found in various sources (e.g., Goldstein & Stainback, 1987). Dobson and Dobson (2018) describe plans for effective exposure sessions, possible targets, and factors that decrease the effectiveness of exposure.

ROLE PLAYING

Role playing is a technique that can be used for a wide variety of purposes. Descriptions of role plays can be found throughout this book, including ones to uncover automatic thoughts, develop an adaptive response, and modify intermediate and core beliefs. Role plays are also useful in learning and practicing social skills.

Some clients have weak social skills in general. Others have good social skills for one kind of communication (e.g., at work but not at home —or vice versa) but lack skills to adapt their style when needed. Abe, for example, is reasonably good at normal social conversation and situations that call for a caring, empathic stance. I asked him, "If you were sure that your cousin would react well, what would you say to her about canceling plans at the last minute?" Abe wasn't sure. He had a skill deficit. So we did a couple of role plays. First I played Abe. Next he played himself. Then I asked him whether anything might get in the way of his having a similar conversation with his cousin. He replied, "She might think I was being critical of her." In this instance, Abe had both a skill deficit and an interfering cognition that we needed to address.

USING THE "PIE" TECHNIQUE

It's often helpful to clients to see their ideas in graphic form. A pie chart can be used in many ways, for instance, helping clients set goals. A pie chart can indicate how much time they're currently devoting to fulfilling their aspirations or values (Figure 19.4). Another use of the pie chart is determining relative responsibility for a given outcome (Figure 19.5).

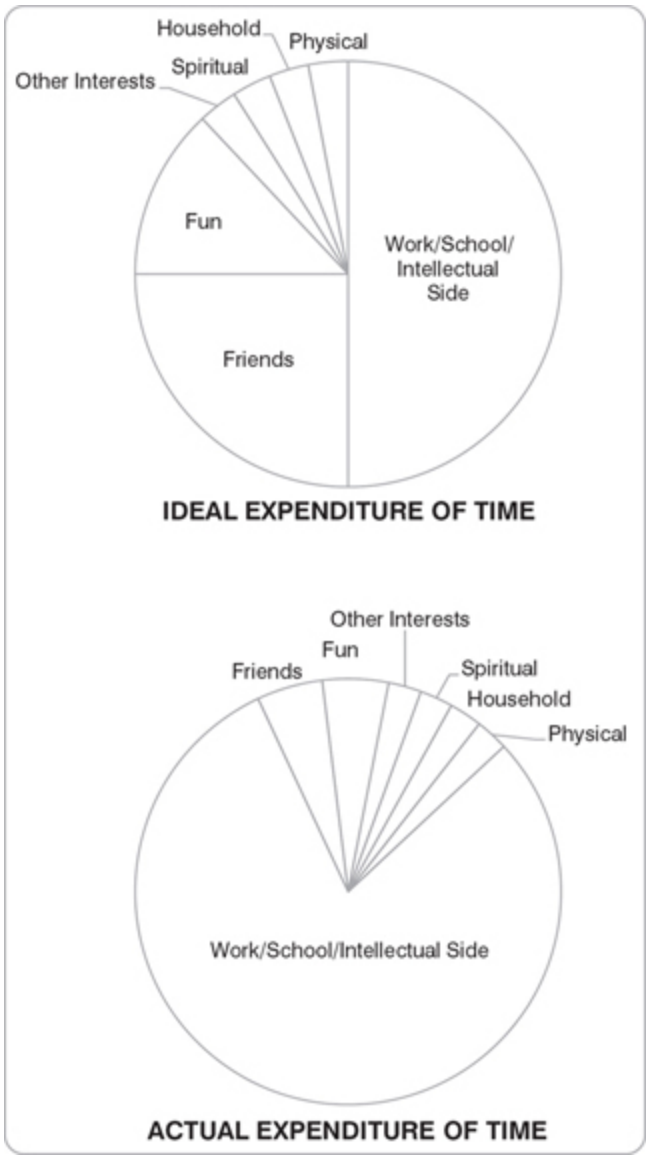


FIGURE 19.4. Pie charts in goal setting.

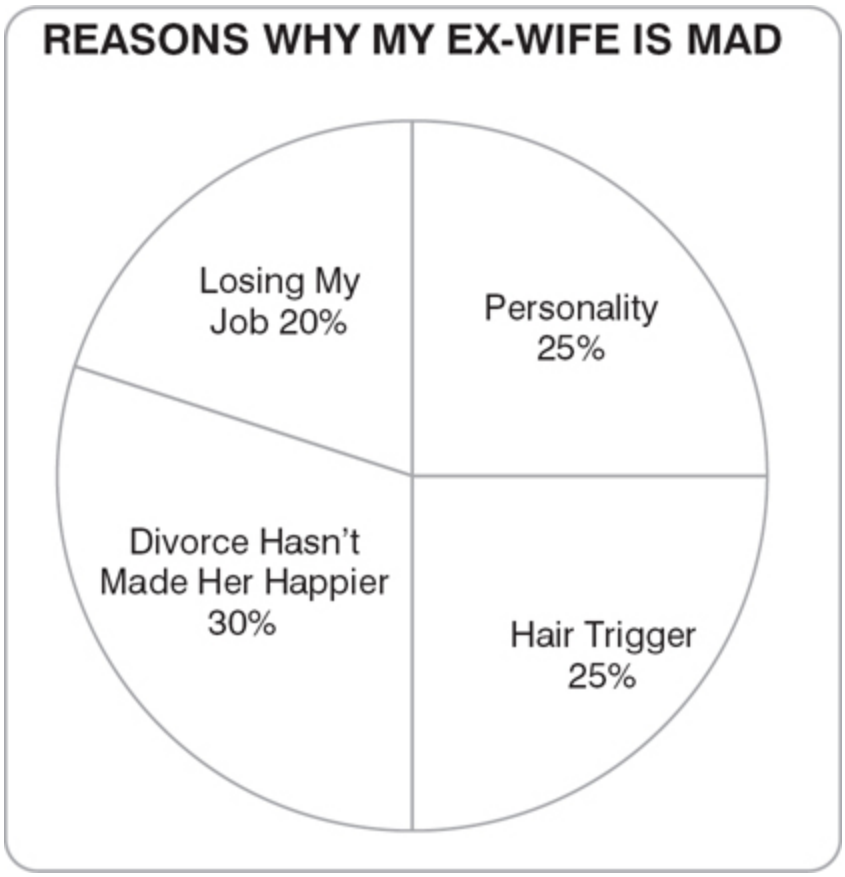


FIGURE 19.5. Pie chart for causality.

JUDITH: Abe, how much do you believe it's your fault that your ex-wife is so mad at you?
ABE: 100%. If I hadn't lost my job, we'd probably still be married.
JUDITH: I wonder if there might be any other explanations?
ABE: (*Thinks.*) Sometimes I wonder if she's really mad at herself. She thought she'd be happier if we got divorced, but she doesn't seem to be.
JUDITH: Anything else?
ABE: I don't know.
JUDITH: Did she get mad even when the marriage was going well?
ABE: Yeah, she tended to be on my back about every little thing.
JUDITH: Did she only get mad at you?

ABE: No, she'd get mad at the kids. She'd get mad at her friends sometimes. Oh, and at her sisters and her parents.
JUDITH: So getting mad seemed to be part of her personality?
ABE: Yeah. I guess so.
JUDITH: Would you say she has a hair trigger for getting mad?
ABE: Yeah. That describes her exactly.
JUDITH: And you obviously didn't lose your job to make her mad.
ABE: No, of course not.
JUDITH: Could we draw a pie chart? (*Draws circle in Figure 19.5.*) I'd like to see how much it's really your fault that she's still mad at you. Okay?
ABE: Sure.
JUDITH: How much of her anger do you think is due to her personality?
ABE: (*Thinks.*) At least 25%.
JUDITH: (*Sections off 25% of the circle and labels it "her personality."*) And to her hair trigger?
ABE: Maybe another 25%.
JUDITH: (*Sections off an additional 25% of the circle and labels it.*) And how much is she really mad at herself because the divorce hasn't made her happier?
ABE: 30%?
JUDITH: (*Sections off 30% and labels it.*) And how much is due to your losing your job?
ABE: Well, there's not much left, is there? 20%, I guess.
JUDITH: (*Labels the remaining 20% of the circle.*) And obviously, you didn't lose your job to *deliberately* make her mad. So now how much do you believe that it's your fault that your ex-wife is so mad?
ABE: Not as much. I guess I didn't think of all those other reasons.

CLINICAL TIPS

When investigating the contribution of alternative explanations, ask clients to estimate the dysfunctional attribution (in this case, "It's my fault") last so they will more fully consider all explanations.

SELF-COMPARISONS

Clients often have automatic thoughts in the form of unhelpful comparisons. They compare themselves at present with how they were before the onset of their disorder, or with how they would like to be, or they compare themselves with others who don't have a psychiatric disorder. Doing so helps to maintain or increase their dysphoria, as it does with Maria. I help her see that her comparisons are unhelpful. I then teach her to make more functional comparisons (with herself at her worst point).

JUDITH: Maria, it sounds as if you were comparing yourself to other people quite a lot this week.
MARIA: Yeah, I guess I was.
JUDITH: And it sounds as if that always made your mood worse.
MARIA: Yeah. I mean, look at me. It was so hard just to do basic stuff, like organizing the living room, paying bills …
JUDITH: Would you be as hard on yourself, for example, if you had to push yourself because you had pneumonia?
MARIA: No, but then I'd have a *legitimate* reason to be tired.
JUDITH: Isn't depression a legitimate reason to be tired? Maybe it's not fair to compare yourself to people who aren't depressed. Do you remember at the first session when we talked about some of the symptoms of depression: tiredness, low energy, trouble concentrating, low motivation, and so on?
MARIA: Uh-huh.
JUDITH: So maybe there's a legitimate reason that you have to push yourself, even though other people don't, or don't have to as much?
MARIA: (*Sighs.*) I guess so …
JUDITH: Okay, can we go over what you can do when you compare yourself with others?
MARIA: (*Nods.*)
JUDITH: What would happen if you said to yourself, "Now wait a minute. That's not a reasonable comparison. Let me compare myself to *me* at my worst point, before I started therapy, when my whole apartment was a mess, and I spent all day in bed or on the couch."
MARIA: Well, I'd realize that I'm doing more now.
JUDITH: And would your mood get worse?
MARIA: No, probably better.
JUDITH: Would you like to try this comparison as part of your Action Plan?

MARIA: Uh-huh.
JUDITH: What do you want to write down?
MARIA: I guess that it's not helpful to compare myself to other people.
JUDITH: Especially people who aren't depressed. And what can you do instead?
MARIA: I could think of what I'm doing now that I wasn't doing before we started working together.
JUDITH: Great—do you want to write those two things down?

Clients may also have automatic thoughts in which they compare themselves at present to where they would like to be. For example, they might say, "I should be able to [work full time]." Or they may compare themselves to where they were before they became depressed ("This used to be so easy for me"). Again, have them focus on how far they've progressed.

CLINICAL TIPS

When clients are at their lowest point, you'll need to modify the approach:

> "It sounds as if you feel pretty down when you compare yourself with other people, or with how you *wish* you were. I wonder if it might be helpful at these times to remind yourself that you have a goal list, and that together we're working on a plan to help you make changes. If you reminded yourself that you and I are a team working to get you to where you want to be, what could happen to your mood?"

SUMMARY

In summary, there are a great variety of techniques used in CBT. Some apply across conditions; some are specific to a particular disorder. Many are adapted from other modalities. These techniques may influence clients' thinking, behavior, and/or physiological arousal, in addition to their mood. Some increase positive affect, some decease negative affect, and some do both. Some techniques help clients regulate their emotions; others teach them skills. You will select techniques, provide a rationale,

elicit the client's agreement, and then employ them. Use your conceptualization of the client as a guide.

REFLECTION QUESTIONS

There are so many techniques you can use in CBT. What advice would you give to a friend who feels overwhelmed at the prospect of how much there is to learn? Which techniques in this chapter might help?

PRACTICE EXERCISES

What is a decision you need to make or can imagine needing to make? Write out the advantages and disadvantages of one option versus another option.

Also, make a pie diagram showing your aspirational use of time versus your actual expenditure of time.

20

IMAGERY

Many clients experience automatic thoughts not only as unspoken words in their minds but also in the form of mental pictures or images (Beck & Emery, 1985). As I'm sitting here now, I can recall several images I had today. As I read an email from a friend, I pictured her in my mind. As I planned a family dinner, I had a visual memory of the last time we all had a meal together. When my client reported an automatic thought ("[My husband] will blame me"), I envisioned her husband speaking to her with a mean look on his face. While most imagery is visual, images can be sensory (such as a tone of voice) or somatic (physiological sensations). Imagery affects how we feel (influencing both positive and negative emotions) more than verbal processes (Hackmann et al., 2011). I've found that many CBT therapists, even very experienced ones, don't use techniques to induce positive images in their clients and/or fail to identify and address their clients' important distressing images.

This chapter answers the following questions:

- How can you help clients create positive images?
- How do you identify and educate clients about spontaneous negative images?
- How do you intervene therapeutically with distressing spontaneous images?

INDUCING POSITIVE IMAGES

In previous chapters, we discussed positive imagery in several ways. For example, we ask clients to imagine achieving their aspirations and goals and living in accordance with their values—along with the positive emotions they would experience if they were able to do so. We may ask clients to envision doing their Action Plans to strengthen their motivation, identify and resolve potential obstacles, and increase the likelihood that they will follow through. Below, you'll find five additional interventions, each of which induces a positive image: focusing on positive memories, rehearsing adaptive coping techniques, distancing, substituting positive images, and focusing on positive aspects of an upcoming situation.

Focusing on Positive Memories

Creating vivid positive imagery can increase clients' positive emotions, motivation, and self-confidence. You can have clients recall memories, relevant to a current or upcoming situation, in which they solved problems, coped well with difficult situations, or experienced success (Hackmann et al., 2011).

JUDITH: [summarizing] It sounds to me as if you've lost a lot of confidence in yourself. Do you think that's right?
ABE: (*Thinks.*) Yes. (*pause*) I keep thinking how hard things are.
JUDITH: Things really *are* harder for you now because of the depression. But I remember you telling me about a really hard period in your life, when you worked for a contractor one summer during high school.
ABE: Yeah, I didn't really know what I was doing at first.
JUDITH: What happened?
ABE: I watched the other guys, saw what they were doing, and then I tried to do the same thing.
JUDITH: Was it hard the whole summer?
ABE: No, eventually I caught on. I mean the work was physically hard, but I did a good job.
JUDITH: Can you imagine yourself back at that time? Maybe your last day of work? Can you see yourself?
ABE: Yeah.
JUDITH: What are you doing?
ABE: Helping another guy putting in beams.

JUDITH: Was it hot?
ABE: It sure was.
JUDITH: Can you see it in your mind's eye? It's hot, you're doing this hard work. (*pause*) How are you feeling?
ABE: Pretty good.
JUDITH: Confident?
ABE: Yes.
JUDITH: Knowing you were doing something hard but doing it well?
ABE: Yes.
JUDITH: Can you see that you're still the same person? Someone who can do hard things? You have depression, true, but you haven't given up. You do hard things every day. And some things, like cleaning up around the house, doing errands, volunteering at the homeless shelter—all of these things have gotten easier, haven't they?
ABE: Yeah, that's true.
JUDITH: Do you think it could help this week if you try to remember more about that summer in high school, where you were faced with a challenge, a hard challenge, and you succeeded? And then remind yourself that you're still the same person and that some things have already become easier.
ABE: Yeah, I could do that.

Rehearsing Adaptive Coping Techniques

You use this technique to help clients practice using coping strategies in imagination. Doing this usually boosts their confidence and their mood and motivates them to use these adaptive behaviors between sessions. Here's how I help Abe at one of our booster sessions.

JUDITH: Okay, you're predicting that you're going to have a rough time on your first day of work?
ABE: Yeah.
JUDITH: When will you first notice your anxiety going up?
ABE: When I wake up.
JUDITH: And what will be going through your mind?
ABE: I'm going to mess up.
JUDITH: What does that look like?

ABE: I'll be sitting in a cubicle, just staring at the computer screen.
JUDITH: Okay, what could you do to calm yourself before you leave for work?
ABE: Remind myself it's natural to feel nervous on your first day in a job.
JUDITH: Can you see yourself doing that?
ABE: Yeah.
JUDITH: Okay, what else can you do?
ABE: I could do my mindfulness practice.
JUDITH: Can you see yourself doing that?
ABE: Yeah.
JUDITH: Then what?
ABE: I feel a little better, but I'm still too nervous for breakfast. I just shower, get dressed, get ready to go.
JUDITH: What's going through your mind?
ABE: What if I keep getting more and more nervous?
JUDITH: How about imagining yourself reading those therapy notes we just composed before you leave your apartment? Can you imagine pulling them out and reading them?
ABE: Yeah … I guess it helps some.
JUDITH: As you get near the building, can you imagine jumping ahead in time. It's lunch time, you've mostly been filling out papers, taking a tour, maybe setting up your email with the IT people … How do you feel now?
ABE: Some relief. Still worried, but not as bad.
JUDITH: Okay, now you've just come back from lunch. What happens next, and what do you do?

Abe continues to imagine in detail realistically coping with the situation. Then he writes down the specific techniques he predicts will help.

Distancing

Distancing is another induced imagery technique to reduce distress and help clients view problems in greater perspective. In the following example, I help Abe see that his difficulties are likely to be time limited.

JUDITH: Abe, I know you're feeling kind of hopeless now, and you're predicting that these problems will go on and on. Do you think it would help if you could envision getting through this rough period?
ABE: I guess. But it's hard to imagine.
JUDITH: Well, let's see. How about if you try to picture yourself a year from now? When you've gotten through this, and you're feeling better?
ABE: Okay.
JUDITH: Any idea what life is like?
ABE: I don't know. It's hard for me to think that far ahead.
JUDITH: Well, let's be concrete. When do you wake up? Where are you?
ABE: Probably I wake up around 7 o'clock or 7:30. I guess I'm in my same apartment.
JUDITH: Okay, can you see yourself waking up? What do you want to imagine you're doing next?

Helping Abe visualize a day in the future when his mood and functioning have improved creates hope and motivation.

Substituting Positive Images

Substituting a more pleasant image has been extensively described elsewhere (e.g., Beck & Emery, 1985). It, too, must be regularly practiced for the client to experience relief from distressing spontaneous images. It's appropriate to use this technique only intermittently when clients experience negative images. If negative images are part of a dysfunctional thought process, then techniques like mindfulness are more suitable.

JUDITH: Abe, another way of dealing with this kind of upsetting image is to substitute a different one. Some people like to imagine that the distressing image is a picture on a television set. Then they imagine changing the channel to a different scene, like lying on a beach, or walking through the woods, or recalling a pleasant memory. Would you like to try this technique?
ABE: Yeah.
JUDITH: First, you'll picture the pleasant scene in as much detail as possible, using as many senses as possible; then I'll have you practice

switching from a distressing image to the pleasant one. Now, what pleasant scene would you like to imagine?

Focusing on Positive Aspects of a Situation

Another type of induced image is designed to allow clients to view a situation more positively. One client, who feared undergoing a Cesarean section, envisioned the excited face of her partner, holding her hand; the kind and caring faces of the nurses and doctor; and then the wonderful image of holding her newborn child.

IDENTIFYING NEGATIVE IMAGES

Although many clients have automatic thoughts in the form of negative visual images, few are aware of them initially. These spontaneous images may last just for milliseconds. Merely asking about them, even repeatedly, is often insufficient. When clients do have distressing images, it's useful to teach them imaginal techniques. Unaddressed images usually result in continued distress.

Here's how I identify one of Abe's negative spontaneous image that involves his ex-wife.

JUDITH: [summarizing] Did I get this right? You were thinking about this upcoming family dinner at your son's house and you thought, "What if Rita criticizes me in front of the family?"

ABE: Yes.

JUDITH: Did you imagine what the scene would look like?

ABE: I'm not sure.

JUDITH: [helping Abe to think very specifically] Could you picture it now? Where would this come up? In the living room or kitchen? Or as you're sitting around the dinner table?

ABE: Around the dinner table.

JUDITH: Okay, can you picture it now? It's Saturday night, you're all sitting around the dinner table … Can you see it in your mind?

ABE: Yes.

JUDITH: What's happening?
ABE: We're talking about the Fourth of July holiday, and Rita says, "Abe, you know you'll just drag everyone down."
JUDITH: When she says that, what does her face look like?
ABE: Kind of mean.
JUDITH: Do you think that image flashed through your mind when you were thinking about the family dinner?
ABE: Yeah, I think so.
JUDITH: Okay. [providing psychoeducation] That picture, what you were imagining, is what we call an image. It's an automatic thought in another form.

TEACHING CLIENTS ABOUT DISTRESSING IMAGES

Clients may not grasp the concept of images if you only use that one term. Synonyms include mental picture, daydream, fantasy, imagining, movie in your mind, and memory. Had Abe failed to report an image, I might have tried using one of these different words. Or I might have reminded him that we created an image in our first therapy session when we identified his aspirations and goals. You must often be diligent in teaching clients to identify images until they "catch on." Most clients simply are unaware of images initially, and many therapists, after a few tries, abandon the attempt. If you get a visual image *yourself* as the client is describing a situation, you can use it as a cue to probe further.

> "Abe, as you were just describing walking into the homeless shelter and feeling overwhelmed, I got a picture of it in *my* head, even though obviously I don't know what the shelter looks like. (*pause*) Have you been imagining what happens as you walk in?"

CLINICAL TIPS

A few clients can identify images but don't report them because their images are graphic and distressing. They may be reluctant to reexperience the distress or fear you will view them as disturbed. If you suspect either scenario, normalize the experience.

> "Lots of people have visual images either instead of or along with their other automatic thoughts. But usually we don't realize it. Sometimes images seem pretty strange, but actually it's common to have all kinds of images—sad, scary, even violent ones. The only problem is if you think *you're* strange for having an image."

MODIFYING SPONTANEOUS NEGATIVE IMAGES

There are two kinds of spontaneous negative images you'll address in treatment. The first kind occurs repeatedly and is experienced as intrusive. You can view them as an unhelpful thought process and use mindfulness techniques (Chapter 16). When images aren't part of a thought process, there are several strategies you can teach clients: changing the "movie," following the image to completion, and reality testing the image. Advise clients that they'll need to practice the techniques in and out of session to use them effectively when their distressing images spontaneously arise.

Changing the "Movie"

Abe reported a spontaneous image he had recently. He saw himself sitting alone in his apartment during the upcoming weekend, feeling sad and lonely. I educate him about images and help him create a new "movie."

JUDITH: Abe, you don't have to be at the mercy of your images. You can change them, if you want. It's as if you're a movie director. You can decide how you want them to be instead.
ABE: I'm not sure I understand how to do that.
JUDITH: Well, okay, you said you saw yourself sitting on the couch, feeling really sad. What do you *wish* would happen next?
ABE: Umm, maybe that my daughter calls and invites me over for dinner.
JUDITH: Can you imagine picking up the phone? How do you feel when she invites you over?
ABE: Better.
JUDITH: Is there any other scenario you'd like to imagine?

ABE: Maybe that I call my cousin and she wants to do something with me.
JUDITH: That's a better movie too.
ABE: But how do I know they'll come true?
JUDITH: Well, first of all, neither of us really knows if you'll actually end up sitting on the couch, all weekend. What we *do* know is that *imagining* it makes you feel really sad now. Second, maybe we could talk about how to make it more likely that there really *is* a better ending. What could you do to make it more likely that you'd get together with your daughter or your cousin?

Following Images to Conclusion

Three techniques help you and clients conceptualize a problem and do cognitive restructuring, to provide relief.

1. Help clients imagine coping with a difficult situation until they've gotten through a crisis or resolved a problem.
2. Suggest that clients imagine the near future when they keep imagining one problem after another after another.
3. Ask clients to jump to the far future (and, when relevant, discuss the meaning of a catastrophe).

Coping with Difficult Experiences

Clients usually feel better and more self-confident when they picture themselves getting through a stressful event.

JUDITH: Okay, Abe, can you get that image in mind again about being interviewed for the job? Tell it to me aloud as you imagine it as vividly as you can.
ABE: I'm sitting in an office. The interviewer is asking me what happened in my last job. My mind is going blank. I'm paralyzed.
JUDITH: And you're feeling …?
ABE: Really, really anxious.
JUDITH: Anything else happen?
ABE: No.

JUDITH: Okay. [providing psychoeducation] This is typical. Your mind automatically stops the image at the very *worst* point. Now I'd like you to imagine what happens next.
ABE: Hmm. I'm not sure.
JUDITH: Well, do you stay that way for the whole interview?
ABE: No, I guess not.
JUDITH: Can you picture what happens next? … Do you begin to talk?
ABE: I guess so.
JUDITH: What do you see happening next?
ABE: I kind of sputter. I tell him that I had done a really good job for over 20 years, but I got a new boss who changed my job and didn't support me when I needed help.
JUDITH: That's really good! Then what happens? Can you see it in your mind's eye?
ABE: He asks me another question about how the job changed.
JUDITH: Then what?
ABE: I answer it okay.
JUDITH: Then what?
ABE: I guess we keep talking until he runs out of questions.
JUDITH: Then what?
ABE: He thanks me for coming in and shakes my hand and I leave.
JUDITH: And how are you feeling in the image now?
ABE: A little shaky. But okay.
JUDITH: Better than at the start when you were feeling blank and paralyzed?
ABE: Yes. Much better.

Jumping to the Near Future

Following an image to the end can be ineffective when clients keep imagining more and more obstacles or distressing events with no end in sight. At this point, you might suggest that clients imagine themselves at some point in the near future, when they're feeling somewhat better.

JUDITH: [summarizing] Okay, Abe, when you imagine doing your taxes, you keep seeing how hard it is and how much effort it's taking and how

many problems you're having with it. Realistically, do you think you'll eventually finish them?

ABE: Yeah, probably. I might have to work on them for days though.

JUDITH: Could you imagine jumping ahead in time and finishing them? Can you picture that? What does it look like?

ABE: Well, I guess I see myself looking them over one last time. Then I print them out and mail them.

JUDITH: Could you slow it down a little, really imagine the details? When is it? Where are you?

ABE: Okay. I'm sitting at the table. It's Sunday, late afternoon. It's hard, and my attention wanders, but I finally finish looking over the form for mistakes.

JUDITH: So, you're finished. How do you feel?

ABE: (*Sighs.*) Relieved … like a weight has been taken off my chest. Lighter.

JUDITH: Okay, let's review what we did. You had an image of yourself starting to work on your taxes, and the more you imagined, the more problems you saw. Then you jumped ahead in time and saw yourself finishing them, which made you feel better. Can we write something down about this technique—jumping ahead in time—so you'll be able to practice it at home too?

Jumping to the Far Future

Sometimes when you guide clients to imagine what happens next, they visualize the scene worsening catastrophically. If so, question clients to determine the *meaning* of the catastrophe and intervene accordingly.

JUDITH: Okay, Maria, so you see your friend in intensive care. What's happening to her?

MARIA: They're trying to help her, but she's too weak from the cancer. She stops breathing.

JUDITH: (*gently*) Then what?

MARIA: (*crying*) She's dead.

JUDITH: Then what happens?

MARIA: I don't know. I can't see past that. (*still crying*)

JUDITH: Maria, I think it'll help if we try to go a little further. What's the worst part about your friend dying? What does it mean to you?
MARIA: I can't survive without her! My life is ruined!

In this example, following the image to completion leads to a catastrophe. I empathize with Maria. Then I gently ask her if she's willing to imagine what she is doing and how she is feeling at her friend's funeral, then a year later, then 5 years later, and finally 10 years later. She is able to see herself with a new best friend in 5 years' time, and she's feeling somewhat better. Jumping ahead in time allows her to see that while she will always feel sorrow, she will be able to continue on with her life and experience peace again. She then feels less desperate about losing this relationship.

Reality Testing the Image

Another technique is to teach clients to treat images as verbal automatic thoughts, using standard Socratic questioning. I teach Maria to compare a spontaneous image with what is really happening.

MARIA: I was out really late last night. When I got to the parking lot, I suddenly saw myself feeling really sick and passing out and having no one there to help me.
JUDITH: Was that accurate? Was the parking lot deserted?
MARIA: (*Thinks.*) No. There were a couple of other people there.
JUDITH: Okay. With this kind of image, when you're spontaneously imagining something happening right at the moment, you can do a reality check. You can ask yourself, "Is the parking lot actually deserted? Am I actually feeling really sick right now?" If you had known to do that last night, what do you think would have happened to your mood?
MARIA: I guess I might have felt a little less nervous.

In general, it is preferable to use techniques in imagery form or combined with verbal techniques when dealing with images, rather than verbal techniques alone. However, clients who have many vivid, distressing images will benefit from a variety of techniques, and sometimes the verbal technique of a reality check is helpful.

SUMMARY

Imagery can be used in various ways to heighten positive emotion, increase confidence, rehearse the use of coping techniques, and change cognition. When clients experience negative images, you may need to use persistent (though gentle and nonintrusive) questioning to help clients recognize their images. Clients who have frequent, distressing images benefit from either regular practice of several imagery techniques or, if their images are intrusive, mindfulness techniques.

Imagery can be used to modify negative core beliefs by reframing the meaning of significant adverse life events (see Appendix D). It can also be used more extensively to create and reinforce new ways of being (Hackmann et al., 2011; Padesky & Mooney, 2005).

REFLECTION QUESTIONS

Why might you induce a positive image with clients? How would you do that? How might you use imaginal techniques to help a client who has had a distressing negative image?

PRACTICE EXERCISE

Try to recall a distressing image you've had. For example, did you feel nervous before you saw your first client? Did you have a mental picture of him or her? Or maybe you had an upsetting image when you were thinking about an upcoming interpersonal interaction (a meeting, a confrontation, a large social gathering, or a presentation) that you thought might be stressful. Did you picture others' faces? Body language? What emotion did you imagine they would be feeling? What did you imagine they would say? Get the image as clearly in mind as you can. Then use techniques in this chapter to respond to the image.

21

TERMINATION AND RELAPSE PREVENTION

Research shows that sessions focused on relapse prevention help delay the onset of relapse and recurrence among depressed clients (de Jonge et al., 2019). The traditional objectives of CBT have been to facilitate a remission of clients' disorders and to teach them skills they can use throughout their lifetime to reduce or prevent relapse. While these objectives are still critical, we now put additional emphases on enhancing positive mood, increasing valued action, strengthening resilience, and improving satisfaction and general well-being.

In this chapter, you will find answers to these questions:

How do you prepare clients for termination?
What do you do from the beginning of treatment? What do you do throughout and at the end of treatment?
How do you taper therapy sessions?
What does a self-therapy session look like?
How do you prepare clients for potential setbacks or relapse?
How do clients react to ending treatment?
How should you conduct booster sessions?

EARLY TREATMENT ACTIVITIES

You begin to prepare clients for termination and relapse even in the initial session, telling them your goal is to teach them skills so they can become their own therapist—which also helps speed up treatment. As soon as clients begin to feel better (often within the first few weeks), it's important to let them know that their recovery will probably not follow a straight line. You might draw them a graph (Figure 21.1) showing them the usual course of progress, with periods of improvement that are typically interrupted (temporarily) by plateaus, fluctuations, or setbacks.

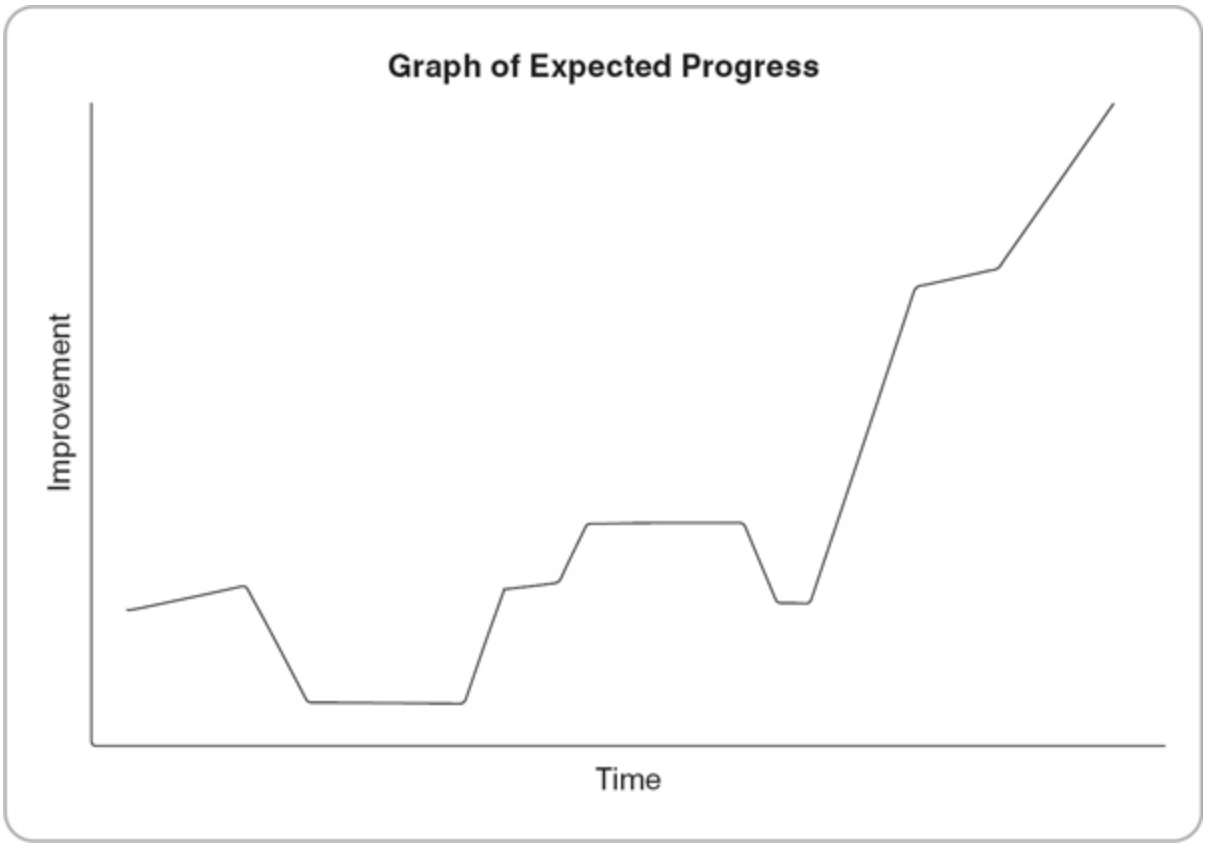


FIGURE 21.1. Graph of expected progress. This graph, if skillfully drawn, can be made to resemble the southern border of the United States, with setbacks represented by "Texas" and "Florida." While striking some clients and therapists as humorous, this illustration may help clients recall that setbacks are normal.

JUDITH: Abe, I'm glad you're feeling a little better. But I should tell you that you may still have ups and downs. Can I draw a graph to show you?

ABE: Uh-huh.

JUDITH: (*drawing*) If you're like most people, you'll go along feeling a little better and a little better; then at some point, you'll reach a temporary plateau or have a setback. That may last for a little while, then you'll feel a little better and a little better, and then you may have another setback, maybe shorter this next time. If you continue to use your skills though, you'll start making progress again, until you're over the depression. (*Points to the graph.*) Can you see that this graph looks a little like the southern border of the United States? So if you have a setback, it just means you're visiting Texas. Pretty soon you'll continue on to Louisiana, Mississippi, Alabama. Then you'll go to Florida, maybe with a detour to Miami. But then you'll recover and get better and get up to Maine. (*pause*) But if you didn't *know* that it's *normal* to visit Texas, what might you think?

ABE: That I'm back to square one. That I'm not going to get better.

JUDITH: Exactly. You'll need to remind yourself that it's *normal* to have ups and downs … You can remember this diagram where we predicted some low points.

ABE: (*taking the graph*) Okay.

JUDITH: Now, even after we're finished therapy, you'll have at least mild ups and downs. Everyone does. Of course, by then, you'll have the tools you need to help yourself. Or you may want to come in again for a session or two. We'll talk about this toward the end of treatment.

ACTIVITIES THROUGHOUT THERAPY

Certain techniques, used throughout treatment, will facilitate relapse prevention.

Attributing Progress to the Client

Be alert at every session for opportunities to reinforce clients for their progress. When they experience an improvement in mood, find out why they think they are feeling better. Emphasize the idea, whenever possible, that they themselves have brought about changes in their mood by making

changes in their thinking and behavior. Point out or ask clients to state what these positive changes mean about them. Doing these things helps build their sense of self-efficacy.

JUDITH: It sounds as if your depression is lower this week. Why do you think that is?
ABE: I'm not sure.
JUDITH: Did you do anything differently this week? Did you do the activities we scheduled? Or did you respond to your negative thoughts?
ABE: Yeah. I cleaned up the apartment some, and I got out almost every day. And I read the therapy notes.
JUDITH: Is it possible you're feeling better this week because you did these things?
ABE: Yes, I think so.
JUDITH: So what can you say about how you made progress?
ABE: I guess when I do things to help myself, I *do* feel better.
JUDITH: That's good. And I think it also shows that even though you're still depressed, you're now able to take more control.
ABE: I guess I am.
JUDITH: [summarizing] So you're feeling better, at least in part, because you took control. This is so important! How about if we write that down?

Some clients attribute all the improvement to a change in circumstance (e.g., "I'm feeling better because my daughter called me") or to medication. Acknowledge the external factors, but also ask about changes *they* made that could have contributed to (or helped maintain) their improvement. When clients persist in believing that they don't deserve credit, you might decide to elicit their underlying belief ("What does it mean to you that I'm trying to give you credit?").

Teaching Skills

When teaching clients techniques and skills, stress that these are lifelong tools they can use in situations now and in the future. Research shows that using CBT skills improves outcomes in clients with recurrent depression, even in the face of stressful life events (Vittengl et al., 2019). Encourage

clients to read and organize their therapy notes so they can easily refer to them in the future. A good Action Plan item is to write a synopsis of the important points and skills they learned in treatment. Common techniques and skills that can be used during and after therapy include the following:

- Setting goals in accordance with their aspirations and values.
- Measuring progress toward achieving their goals.
- Using CBT techniques to overcome obstacles.
- Monitoring positive experiences and drawing conclusions about what these experiences indicate about the client.
- Balancing productive, pleasurable, self-care, and social activities.
- Giving self-credit.
- Cultivating positive memories.
- Reducing large goals, problems, or tasks to manageable components.
- Brainstorming solutions to problems.
- Identifying advantages and disadvantages (of specific thoughts, beliefs, or behaviors, or choices when making a decision).
- Using worksheets or a list of Socratic questions to evaluate thoughts and beliefs.
- Working on hierarchies of avoided tasks or situations.

Help clients understand how they can use these skills in other situations during and after therapy, whenever they perceive they're having a reaction that seems out of proportion to the situation. For example, they may recognize that they're feeling more anger, anxiety, sadness, or embarrassment than a situation calls for. Or perhaps they see a pattern of unhelpful behavior that they want to change.

Building Resilience and Well-Being

There are a number of ways to help clients become more resilient and increase their sense of well-being. A good guide is provided by the American Psychological Association (*www.apa.org/helpcenter/road-resilience*). It stresses many of the interventions in this book: making connections, modifying catastrophic thinking, maintaining optimism about the future, accepting situations or conditions that can't be changed, working toward goals, decreasing avoidance when challenges occur, identifying ways to grow as a person when encountering adversity, strengthening positive core beliefs, seeking a broader perspective in

stressful situations, doing good self-care, and engaging in meditation or a spiritual practice.

Clients often lose confidence in themselves when they become depressed. It's critical for them to build their resilience and increase their confidence so they can handle difficult times in the future without becoming depressed again. Many techniques from positive psychology, as described by Martin Seligman, PhD, in books for consumers, and from many other authors writing for professionals (e.g., Bannink, 2012; Chaves et al., 2019; Jeste & Palmer, 2015), promote a better sense of well-being.

NEAR-TERMINATION ACTIVITIES

Tapering Treatment

If a client has a limited number of sessions with you, discuss tapering several weeks before termination. If there isn't a limit, hold this discussion when clients are feeling at least somewhat better and are using their skills consistently and effectively. Your objective is not to solve all your clients' problems or to help them reach all their goals. In fact, if you view yourself as responsible to do this, you risk engendering or reinforcing dependence—and you deprive clients of the opportunity to test and strengthen their skills.

Make a collaborative decision to space sessions as an experiment. Initially, consider meeting every other week instead of every week. If that goes well for at least a couple of sessions, you might suggest scheduling the following appointment for 3 or 4 weeks in the future. You might have several monthly sessions before termination and several widely spaced booster sessions after that.

Concerns about Tapering Sessions

Although some clients readily agree to spacing sessions, others may become anxious. If so, ask them to verbally list (and perhaps record in writing) the advantages and disadvantages of trying to reduce the frequency of their visits (Figure 21.2). When clients fail to see advantages,

first elicit disadvantages, use guided discovery to help them identify advantages, and then help them reframe the disadvantages. Some clients, like Maria, might have a strong reaction that you need to attend to.

Advantages of Tapering Sessions

- Save money.
- Can use the time for something else.
- I'll be proud of myself for solving my own problems.
- It will boost my confidence.
- Won't have to travel to [my therapist's] office.

Disadvantages with Reframe

- I might relapse, *but* if I'm going to, it's better for it to happen while I'm still in therapy so I can learn how to handle it.
- I may not be able to solve problems myself, *but* tapering therapy gives me the chance to test my idea that I need [my therapist]. In the long run, it's better for me to learn to solve problems myself, because I won't be in therapy forever. I can always schedule an earlier session if I need to.
- I'll miss [my therapist]. This is probably true, *but* I'll be able to tolerate it and it will encourage me to build up a support network.

FIGURE 21.2. Client's list of advantages and disadvantages of tapering therapy.

JUDITH: In our last session, we talked about experimenting with spacing our therapy sessions. Did you think about going to an every-other-week schedule?

MARIA: I did. It made me really anxious.

JUDITH: What went through your mind?

MARIA: Oh, what if something happens that I can't deal with? What if I start getting more depressed—I couldn't stand that.

JUDITH: Did you answer these thoughts back?

MARIA: Yeah. I read my therapy notes. I mean, it doesn't have to be the absolute end of therapy. And you did say I could call you and come in sooner if I needed to.

JUDITH: That's right. Did you imagine a specific situation that might come up that would be difficult?

MARIA: No, not really.

JUDITH: Maybe it would help if we had you imagine a specific problem now.

MARIA: Okay.

Maria imagines getting into another fight with her best friend. She identifies and responds to her automatic thoughts and makes a specific plan for what to do next.

JUDITH: Now, let's talk about the second automatic thought you had about spacing our sessions—that you'd get more depressed and that you wouldn't be able to stand it.

MARIA: I guess that may not be quite true. I could stand to feel bad again. But I wouldn't like it.

JUDITH: Okay. Now let's say you *do* get more depressed and it's still a week and a half before our next session. What can you do?

MARIA: Well, I can do what I did about a month ago when you were on vacation. Reread my therapy notes, stay active … Somewhere in my notes I have a list of things to do.

JUDITH: Would it be helpful to find that list this week?

MARIA: Yeah.

JUDITH: Okay. How about for your Action Plan if you find the list and also do a worksheet on these two thoughts: "Something might happen that I couldn't deal with" and "I couldn't stand it if I got more depressed."

MARIA: Okay.

JUDITH: Any other thoughts about spacing our sessions?

MARIA: Just that I'd miss not having you to talk to every week.

JUDITH: (*genuinely*) I'll miss that too. (*pause*) Is there anyone else you could talk to, even a little?

MARIA: Well, I could call Rebecca. And I guess I could call my brother.

JUDITH: Those sound like good ideas. Do you want to write them down to do too?

MARIA: Yes.

JUDITH: And finally, do you remember that we said we could *experiment* with every-other-week sessions? If it's not working well, I do want you to call me so we can decide together if you should come in sooner.

SELF-THERAPY SESSIONS

Although many clients don't follow through with formal self-therapy sessions, it's nevertheless useful to discuss a self-therapy plan (see Figure 21.3) and to encourage its use. When clients try self-therapy sessions while regular therapy sessions are still being tapered, they are much more likely to do self-therapy after termination. And they can discover potential problems: insufficient time, misunderstandings about what to do, and interfering thoughts (e.g., "This is too much work"; "I don't really need to do it"; "I can't do it on my own"). In addition to helping clients respond to these cognitions, you can elicit the advantages of self-therapy sessions:

- They are continuing therapy, but at their own convenience and without charge; they can keep their newly acquired tools fresh and ready to use.
- They can resolve difficulties before they become major problems.
- They reduce the possibility of relapse.
- They can use their skills to enrich their life in a variety of contexts.

Think about the past week(s):

What positive things have happened? What did these experiences mean to me? About me? What do I deserve credit for?

What problems came up? If they're not resolved, what do I need to do?

Did I complete the Action Plan? What could get in the way of completing it this coming week?

Look forward:

How do I want to feel by this time next week? What do I need to do to make that happen?

What goals do I have for this week? What steps should I take?

What obstacles could get in the way? Should I consider

- Doing worksheets?
- Scheduling pleasure, mastery, self-care, or social activities?
- Reading therapy notes?
- Practicing skills such as mindfulness?
- Keeping a credit list or positive experience list?

FIGURE 21.3. Guide to self-therapy sessions.

You can review Figure 21.3 with clients and tailor it to meet their needs. Before your final session with clients, encourage them to continue having self-therapy sessions at least once a month, then once a season, and eventually, once a year. Help them devise a system so they'll remember to do this.

PREPARING FOR SETBACKS AFTER TERMINATION

As you near the end of clients' regularly scheduled appointments, ask them what automatic thoughts they may have if they experience a setback. Sometimes clients predict they'll think:

"I shouldn't be feeling [down] this way"
"This means I'm not getting better"
"I'm hopeless"
"I'll never be able to get well and stay well"
"My therapist will be disappointed"

or

"My therapist didn't do a good job"
"CBT really didn't work for me"
"I'm doomed to be depressed forever"
"It was only a fluke that I felt better before"

Or clients may report an image of themselves in the future, for example, feeling frightened, alone, sad, huddled in bed. Socratic questioning and imaginal techniques can help them respond to these distressing cognitions.

Recognizing the Signs of a Setback or Relapse

Toward the end of treatment, it's helpful to discuss with clients the early warning signs they might experience that indicate they're starting to become depressed again and make sure to record them in their therapy notes. Therapy notes should also contain important points to remember and instructions on what to do if their symptoms recur (see Figure 21.4).

Early warning signs—Sad mood, anxiety, rumination, spending too much time on the couch, desire to avoid socializing, letting apartment get messy, procrastinating (e.g., not paying bills), trouble sleeping, self-criticism.

What to remember—I have a choice. I can catastrophize about the setback, think things are hopeless, and probably feel worse. Or I can look back over my therapy notes, remember that setbacks are a normal part of recovery, and see what I can learn. Doing these things will probably make me feel better and make the setback less severe.

What to do—If some of these things happen, have a self-therapy session. Set new goals, evaluate automatic thoughts, schedule activities, do mindfulness if I'm ruminating, see what problems need solving, and especially—reach out for help—to kids and to Charlie. If this isn't enough, call Judith so we can decide together whether I should return to treatment, probably briefly.

FIGURE 21.4. Abe's therapy notes about setbacks.

Clients' Reactions to Termination

As termination approaches, it's important to elicit clients' automatic thoughts about ending treatment. Some clients are excited and hopeful. At the other extreme, some clients are fearful or even angry. Most have some mixed feelings. They are pleased with their progress but concerned about relapse. Often, they are sorry to end their relationship with you. Make sure to acknowledge what clients are feeling and help them respond to distortions or unhelpful cognitions.

It's often desirable for you to express your own genuine feelings, if you can honestly say that you regret the ending of the relationship but feel pride in what clients have achieved—and that you believe they're ready to make it on their own. Some clients say, "I wish you could be my friend." A good response, but only if you mean it, is "Wouldn't that be nice? But then I couldn't be your therapist in the future if you needed me. And it's important to me to be here for you."

BOOSTER SESSIONS

Encourage clients to schedule booster sessions after termination; a good schedule is after 3, 6, and 12 months. You can give clients the "Guide to Booster Sessions" (Figure 21.5); you can also use it to structure these sessions. Knowing in advance that you'll ask them about their progress in doing self-therapy may motivate them to do their Action Plans and practice their skills. And when clients know they are scheduled for booster sessions after termination, their anxiety about maintaining progress may decrease.

1. Schedule ahead—make definite appointments, if possible, and call to confirm.
2. Consider coming as a preventive measure, even if you have been maintaining your progress.
3. Prepare before you come. Decide what would be helpful to discuss, including the following:
   a. What has gone well? What do these experiences imply about you? About how others see you? About the future?
   b. How much do you believe your new core beliefs—at both an intellectual and emotional level? How can you keep strengthening them?
   c. To what degree are you living in accordance with your values? What goals do you have now? What obstacles might arise? How can you handle them?
   d. What CBT techniques have you been using? Did you have self-therapy sessions? Would they be useful to have in the future?

FIGURE 21.5. Guide to Booster Sessions.

SUMMARY

In summary, relapse prevention is carried out throughout treatment. It's important to prepare clients for an upcoming tapering of sessions and the ending of treatment. Particular interventions are important at this time, including encouraging clients to do self-therapy sessions, identifying early warning signs of a potential setback or relapse, and creating a plan of what clients can do if they become more symptomatic. Problems in tapering sessions and in termination are addressed as any other problems, with a

combination of problem solving and responding to dysfunctional thoughts and beliefs. Clients' concerns or regrets about ending treatment need to be handled sensitively.

REFLECTION QUESTIONS

What can you do to decrease clients' distress about termination? What can you do to increase the likelihood that they will continue to use their CBT skills after termination?

PRACTICE EXERCISE

Imagine that you're a client who is nearing the end of treatment. Write a therapy note that will help you with your anxiety.

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PROBLEMS IN THERAPY

Problems of one kind or another arise with many clients. Even experienced therapists encounter difficulties at times when establishing the therapeutic relationship, conceptualizing a client's difficulties, or consistently working toward joint objectives. You *shouldn't* be able to help every client (or help every client enough). *I* certainly haven't helped every client over the course of my career. It's *not* reasonable to expect yourself to avoid problems. It *is* reasonable to develop your skills in uncovering problems, specifying them, conceptualizing how they arose, and developing a plan to remediate them.

It's useful to view problems or stuck points in therapy as opportunities for you to refine your conceptualization of the client. In addition, problems in therapy often provide insight into problems the client experiences outside the office. Finally, difficulties with one client provide an opportunity for you to refine your own skills, to promote your flexibility and creativity, and to gain new understandings and expertise in helping other clients, as problems can arise related to both clients' characteristics and therapists' relative weaknesses. This chapter describes how to identify difficulties in treatment and how to conceptualize and remediate these problems.

You will find the answers to these questions in this chapter:

- How do you know if there's a problem in treatment?
- How can you conceptualize problems?
- What kind of problems can arise?

UNCOVERING THE EXISTENCE OF A PROBLEM

You can uncover a problem in a several ways:

- By listening to clients' unsolicited feedback and by directly eliciting their feedback, during and at the end of the session.
- By periodically asking clients to summarize what you've just discussed in session and checking on their depth of understanding and agreement.
- By tracking improvement according to objective tests and the client's subjective reports, and measuring progress toward goals.
- By reviewing recordings of therapy sessions alone or with a colleague or supervisor and rating the tape on the Cognitive Therapy Rating Scale (*beckinstitute.org/CBTresources*).

Elicit clients' permission to record therapy sessions to review with a peer or an experienced and competent CBT therapist or supervisor. Obtaining clients' consent is usually not a problem if you present it in a positive light:

> "I have an unusual opportunity for you that I can only offer a few clients [or 'that I'm only offering to you']. I want you to feel free to say yes or no. I occasionally record therapy sessions so [my supervisor] and I can listen to them and figure out how I might be able to be more helpful. If we record our sessions, you'll get the benefit of [his or her] input. I'll keep your name confidential, and we'll delete the recording immediately after listening to it. (*pause*) Is it okay with you if we start taping the session now? If it bothers you after a few minutes, we can always turn it off or delete the recording at the end of the session."

CONCEPTUALIZING PROBLEMS

Having recognized that a problem exists, try to understand your clients' internal reality. How do they view themselves, others, and their world? How do they process their experiences? What obstacles might inhibit their ability to take a more functional perspective of their difficulties? Be alert for automatic thoughts blaming clients (e.g., "They're resistant/manipulative/unmotivated"). These labels tend to alleviate a therapist's sense of responsibility for resolving the difficulty and to interfere with problem solving. Instead, ask yourself:

> "What has the client said (or not said) or done (or not done) in session (or between sessions) that's a problem?"

You might ask the same question about yourself, to rule out a mistake you may have made.

Next, you would ideally consult with a supervisor who has reviewed a recording of the entire therapy session. You will undoubtedly need help in determining whether the problem is related to the client's dysfunctional cognitions and behaviors, errors you have made, treatment factors (such as the level of care, format of therapy, or session frequency), and/or factors external to treatment (e.g., an organic disease, a psychologically toxic home or work environment, ineffective medication or deleterious side effects, or an absence of needed adjunctive treatments; J. S. Beck, 2005).

Having identified a problem that calls for a change in what you're doing, conceptualize the level at which the problem occurred:

- Is it merely a *technical problem*? For example, did you use an inappropriate technique or use a technique incorrectly?
- Is it a more *complex problem with the session as a whole*? For example, did you correctly identify a key dysfunctional cognition but then fail to intervene effectively?
- Is there an ongoing problem across several sessions? For example, has there been a breakdown in collaboration?

TYPES OF PROBLEMS

Typically, problems occur in one or more of the following categories:

1. Diagnosis, conceptualization, and treatment planning
2. The therapeutic relationship
3. Motivation
4. Structure and pace of the session
5. Socialization to treatment
6. Responding to dysfunctional cognitions
7. Accomplishing therapeutic goals in and across sessions
8. Processing session content

The following questions can help you and your supervisor specify the nature of a therapeutic problem. Then you can formulate, prioritize, and select one or more specific objectives on which to focus.

Diagnosis, Conceptualization, and Treatment Planning

Diagnosis

"Have I made a correct diagnosis according to the latest *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) or *International Statistical Classification of Diseases and Related Health Problems* (*ICD*)?"

"Is a medication or medical consult indicated for this client?"

Conceptualization

"Have I identified the client's positive beliefs, attributes, strengths, and resources?"

"Have I continually refined the CCD to identify his most central dysfunctional cognitions and behaviors?"

"Do I continually share my conceptualization with her at strategically appropriate times? Does the conceptualization make sense and 'ring true' to her?"

Treatment Planning

"Have I based treatment on my individual conceptualization of the client? Do I continually modify his treatment when needed, based on my conceptualization?"

"Have I varied standard CBT, when needed, for her strong preferences and relevant characteristics: gender, culture, age, education level, and so forth?"

"Have I addressed the need for a major life change (e.g., a new job, a new living situation) if it's apparent that improvement via therapy alone is unlikely?"

"Have I incorporated skills training when needed?"

"Have I included family members in treatment as appropriate?"

The Therapeutic Relationship

Collaboration

"Have the client and I truly been *collaborating*? Are we functioning as a team? Are we both working hard? Do we both feel responsible for progress?"

"Have we been working on what's most important to him?"

"Have we agreed on the goals for treatment?"

"Have I elicited agreement with and provided the rationale for interventions and Action Plans?"

"Have I guided her to an appropriate level of adherence and control in the therapy session?"

Feedback

"Have I regularly encouraged the client to provide honest feedback?"

"Have I monitored his affect during the session and elicited automatic thoughts when I noticed a shift?"

"Have I responded effectively to her negative feedback?"

Client's View of Therapy and Therapist

"Does the client have a positive view of therapy and of me?"

"Does he believe, at least to some degree, that therapy can help?"

"Does he see me as competent, collaborative, and caring?"

Therapist's Reactions

"Do I care about this client? Does my caring come across?"

"Do I feel competent to help her? Does my sense of competence come across?"

"Do I have negative cognitions about her or about myself with respect to this client? Have I evaluated and responded to these cognitions?"

"Do I see problems in the therapeutic alliance as an opportunity for enhancing progress versus assigning blame?"

"Do I project a realistically upbeat and optimistic view of how therapy can help?"

Motivation

"How motivated does the client seem?"

"What have I done to motivate him? Do we regularly link his goals and actions to his aspirations and values?"

"Does he see advantages for *not* getting better?"

[When relevant] "Have I addressed his sense of helplessness or hopelessness?"

Structuring and Pacing the Therapy Session

Agenda

"Do we quickly set a complete and specific agenda toward the beginning of the session?"

"Do we prioritize agenda topics and decide how to split our time?"

"Do we collaboratively decide which topic to discuss first?"

"Do we collaboratively make sound decisions about deviating from the agenda?"

Pacing

"Do we allot and spend an appropriate amount of time for the standard session elements: mood check, setting the agenda, update and Action Plan review, discussion of agenda topic(s), setting new Action Plans, periodic summaries, and feedback?"

"Do we collaboratively decide what to do if more time is needed for a problem than we have allotted?"

"Do I appropriately and gently interrupt the client when needed? Do we spend too much time on unproductive discourse?"

"Do I ensure that she will remember the most important points of the session and is highly likely to complete the new Action Plan? Does she feel emotionally stable before I end the session?"

Socializing the Client to Treatment

Goal Setting

"Has the client set reasonable, concrete goals based on his/her values and aspirations? Does the client keep these goals in mind throughout the week? Is he committed to working toward thevse goals? Are these goals under his control, or is he trying to change someone else?"

"Do we periodically review progress toward his goals?"

"Do I help him firmly keep in mind why it's worth it to work in therapy (i.e., to achieve his aspirations and live life according to his values)?"

Expectations

"What are the client's expectations for herself and for me?"

"Does the client believe all her problems can be solved quickly and easily? Or that I alone should solve her problems? Does she understand the importance of taking an active, collaborative role?"

"Does she understand the necessity of learning skills and using them regularly between sessions?"

Problem Solving/Goal-Focused Orientation

"Does the client specify issues to work on or goals to work toward?"

"Does he collaborate with me to solve problems instead of just airing them?"

"Does he fear solving current problems because then he will have to tackle other problems (such as a decision about a relationship or work)?"

Cognitive Model

"Does the client understand that

- automatic thoughts influence emotion and behavior (and sometimes physiology)?
- some automatic thoughts are distorted and/or unhelpful?
- she can feel better and behave in a more adaptive way when she evaluates and responds to her thinking?"

Action Plan

"Have we designed Action Plans around the client's key issues, goals, and values?"

"Does he understand how the Action Plan relates to the work of the therapy session and to his overall values and goals?"

"Does he think about our therapy work throughout the week and complete Action Plans thoroughly?"

Responding to Dysfunctional Cognitions

Identifying and Selecting Key Automatic Thoughts

"Do we identify the actual words and/or images that go through the client's mind when she is distressed?"

"Do we identify the range of her relevant automatic thoughts?"

"Do we select key thoughts to evaluate (i.e., the thoughts associated with the most distress or dysfunction)?"

Responding to Automatic Thoughts and Beliefs

"Do we identify the client's key cognitions *and* also evaluate and respond to them?"

"Do I avoid assuming a priori that his cognitions are distorted? Do I use guided discovery and avoid persuasion and challenge?"

"If one line of questioning is ineffective, do I try other ways?"

"Are some of his automatic thoughts part of a dysfunctional thought process? If so, have I taught him to disengage from the thought and focus on valued action?"

"Having collaboratively formulated an alternative response, do I check to see how much he believes it? Does his distress decrease?"

"If needed, do we try other techniques to reduce his distress? Do we mark relevant cognitions for future work?"

Maximizing Cognitive Change

"Do we record the client's new, more functional understandings for her to read as part of her Action Plans?"

Accomplishing Therapeutic Goals in and across Sessions

Identifying Overall and Session-by-Session Objectives

"Have I appropriately expressed to the client that the objective of treatment is not only to get better but also to learn skills to stay better?"

"Do I help him identify one or more important issues or goals to discuss in each session?"

"Do we devote time to both problem solving *and* cognitive restructuring?"

"Do Action Plans incorporate both behavioral and cognitive change?"

Maintaining a Consistent Focus

"Do I use guided discovery to help the client identify relevant positive and negative beliefs?"

"Can I state which of her beliefs are most central and which are narrower or more peripheral?"

[Toward the middle of treatment] "Do I consistently explore the relationship of new obstacles to her central beliefs? Are we doing consistent, sustained work on her central beliefs [both positive and negative] at each session instead of only crisis intervention?"

"If we have discussed childhood events, was there a clear rationale for why we needed to do so? Have I helped her see how her early beliefs relate to current difficulties and how such insight can help in the coming week? Or how early experiences support her positive beliefs?"

Interventions

"Do I choose interventions based on both my goals for the session and the client's agenda?"

"Do I check how distressed he felt and/or how strongly he endorsed an automatic thought or belief both before and after an intervention so I could judge how successful the intervention was?"

"If an intervention is relatively unsuccessful, do I switch gears and try another approach?"

Processing Session Content

Monitoring Clients' Understanding

"Have I summarized [or asked the client to summarize] frequently during the session?"

"Have I asked her to state her conclusions in her own words?"

"Have I been alert for nonverbal signs of confusion or disagreement?"

Conceptualizing Problems in Understanding

"Have I checked out my hypotheses with the client?"

"If he has difficulty understanding what I am trying to express, is it due to a mistake I have made? To my lack of concreteness? To my vocabulary or level of abstraction? To the amount of material I'm presenting in one chunk or in one session?"

"Is a difficulty in understanding due to his level of emotional distress in the therapy session? To distraction? To automatic thoughts he is having at the moment?"

Maximizing Consolidation of Learning

"What have I done to ensure that the client will remember key parts of the therapy session during the week and even after therapy has ended?"

"Have I motivated her to read therapy notes daily?"

STUCK POINTS

At times, clients may feel better during individual sessions but fail to make progress over the course of several sessions. If you're an experienced CBT therapist, you may not need to ask yourself the preceding questions. Instead, first make sure that you have a correct diagnosis, conceptualization, and treatment plan tailored for the client's

disorder (and have correctly employed techniques). Then you can assess the following, alone or with a supervisor:

"Do the client and I have a solid *therapeutic alliance*?"
"Do we both have a clear idea of his *values and goals* for therapy? Is he committed to working to achieve these goals?"
"Does the client truly believe the *cognitive model* [that her thinking influences her mood and behavior, that her thoughts may be inaccurate or unhelpful, and that responding to her dysfunctional cognitions positively affects her emotions and behavior]?"
"Is the client *socialized* to CBT—does he contribute to the agenda, collaboratively work toward resolving problems and obstacles, do Action Plans, and provide feedback?"
"Is the client's *biology* [e.g., illness, medical condition, medication side effects, or inadequate level of medication] or her *external environment* [e.g., an abusive partner, an extremely demanding job, or an intolerable level of poverty or crime in her environment] interfering with our work together?"

REMEDIATING PROBLEMS IN THERAPY

Depending on the identified problem, you might consider the advisability of one or more of the following:

1. Doing a more in-depth diagnostic evaluation
2. Referring the client for a medical or neuropsychological examination
3. Refining your conceptualization and checking it out with the client
4. Reading more about the treatment of the client's disorder(s)
5. Seeking specific feedback from the client about his experience of therapy and of you
6. Reestablishing the client's aspirations, values, and goals for therapy (and possibly examining the advantages and disadvantages of working toward them)
7. Reviewing the cognitive model with the client (and eliciting doubts or misunderstandings)
8. Reviewing the treatment plan with the client (and eliciting concerns or doubts)
9. Assessing the client's expectations for how she's going to get better (What does she think you need to do? What does she think she needs to do?)
10. Emphasizing setting and reviewing Action Plans in session and accomplishing Action Plans throughout the week
11. Working consistently on key automatic thoughts, beliefs, and behaviors across sessions
12. Checking on the client's understanding of session content and recording the most important points
13. Based on the client's needs and preferences, changing (in one direction or the other) the pace or structure of the session, the amount or difficulty of material covered, the degree of empathy you've been expressing, the degree to which you have been didactic or persuasive, and/or the relative focus on resolving obstacles

In addition, you should monitor your own thoughts and mood when seeking to conceptualize and remediate difficulties in therapy because your cognitions may at times interfere with problem solving. It's likely that all therapists, at least occasionally, have negative thoughts about clients, the therapy, and/or themselves as therapists. Typical therapist assumptions that interfere with making changes include:

> "If I interrupt the client, he'll think I'm controlling him."
> "If I structure the session with an agenda, I'll miss something important."
> "If I record a session, I'll be too self-conscious."
> "If my client gets annoyed with me, she'll drop out of therapy."

You may benefit from a model of personal practice in which you reflectively focus on your development, both personal and professional, on an ongoing basis. A workbook can facilitate this work (Bennett-Levy et al., 2015).

Finally, when you encounter a problem in treatment, you have a choice. You can catastrophize about the problem and/or blame yourself or the client. Alternatively, you can turn the problem into an opportunity to refine your skills of conceptualization, treatment planning, and establishing a sound therapeutic relationship. Difficulties often provide opportunities to improve your technical expertise and your ability to vary therapy for the specific needs of each client.

SUMMARY

You are bound to face challenges in treatment. It's important not to blame yourself or the client. Some difficulties arise because you're human and, therefore, fallible. Other difficulties arise because your client is human and, therefore, fallible. You may very well learn the most from clients who have been challenging to treat.

At every session, it's important to monitor clients' emotional experience, cognitions about therapy and about you, their depth of understanding, and their progress so you can uncover problems. When you do identify a problem, conceptualize it. Is there something the client is

doing or not doing or saying or not saying in session or between sessions that's a problem? Is there a problem with something *you're* doing or not doing or saying or not saying that's a problem? Is it a limited problem or a more general one? Use the questions in this chapter to diagnose what's going on and create a plan to improve treatment.

REFLECTION QUESTIONS

Which kinds of problems do you think you'll have most difficulty handling? Why? What can you do?

PRACTICE EXERCISE

Imagine that you have a client who has failed to make progress for the past four sessions. Write a plan for how you can improve the situation.

APPENDIX A

CBT Resources

For principles of CBT, worksheets, videos, conceptualization diagrams, the case summary outline, and the Cognitive Therapy Rating Scale and manual, visit *beckinstitute.org/CBTresources*.

TRAINING PROGRAMS

The Beck Institute for Cognitive Behavior Therapy in suburban Philadelphia offers a variety of on-site, off-site, and online training programs for individuals and organizations worldwide, along with supervision and consultation programs (*beckinstitute.org*).

ADDITIONAL RESOURCES

- Worksheet packet
- Client booklets
- Books, CDs, and DVDs by Aaron T. Beck, MD, and Judith S. Beck, PhD

- Videos with Aaron T. Beck, Judith S. Beck, and Beck Institute clinicians

BECK CBT CERTIFICATION

Information about the Beck CBT Certification program and certified clinician's directory (in press).

CONNECT WITH THE BECK INSTITUTE

- Monthly newsletter with CBT tips, news, and announcements
- Blog with articles from Beck Institute leadership and faculty
- Links to the Beck Institute's social accounts

ASSESSMENT MATERIALS

The following scales and manuals may be ordered from Pearson (*www.pearsonassessments.com*):

- Beck Youth Inventories of Emotional and Social Impairment® (BYI®)—Second Edition (for children and adolescents ages 7–18)
- Beck Anxiety Inventory® (BAI®)
- Beck Depression Inventory® (BDI®)
- Beck Scale for Suicide Ideation® (BSS®)
- Beck Hopelessness Scale® (BHS®)
- Clark–Beck Obsessive–Compulsive Inventory® (CBOCI®)
- BDI®—Fast Screen for Medical Patients

The following scales and manuals can be found at *www.beckinstitute.org*:

- Personality Belief Questionnaire
- Personality Belief Questionnaire—Short Form
- Dysfunctional Attitude Scale

APPENDIX B

Beck Institute Case Write-Up

SUMMARY AND CONCEPTUALIZATION

PART ONE: INTAKE INFORMATION

Identifying Information at Intake

Age: 56

Gender Identity and Sexual Orientation: Male, heterosexual

Cultural Heritage: American with European heritage

Religious/Spiritual Orientation: Belongs to the Unitarian Church; was not attending church at intake

Living Environment: Small apartment in large city; lives alone

Employment Status: Unemployed

Socioeconomic Status: Middle class

Chief Complaint, Major Symptoms, Mental Status, and Diagnosis

Chief Complaint: Abe sought treatment for severe depressive symptoms and moderate anxiety.

Major Symptoms

Emotional: Feelings of depression, anxiety, pessimism, and some guilt; lack of pleasure and interest

Cognitive: Trouble making decisions, trouble concentrating

Behavioral: Avoidance (not cleaning up at home, looking for a job, or doing errands), social isolation (stopped going to church, spent less time with family, stopped seeing friends)

Physiological: Heaviness in body, significant fatigue, low libido, difficulty relaxing, decreased appetite

Mental Status: Abe appeared to be quite depressed. His clothes were somewhat wrinkled; he didn't stand or sit up straight, made little eye contact, and didn't smile throughout the evaluation. His movements were a little slow. His speech was normal. He showed little affect other than depression. His thought process was intact. His sensorium,

cognition, insight, and judgment were within normal limits. He was able to fully participate in treatment.

Diagnosis (from the *Diagnostic and Statistical Manual of Mental Disorders* or the *International Statistical Classification of Diseases and Related Health Problems*): Major depressive disorder, single episode, severe, with anxious distress. No personality disorder but mild obsessive–compulsive personality disorder features.

Current Psychiatric Medications, Adherence, and Side Effects; Concurrent Treatment

Abe was not taking psychiatric medication and was not receiving any treatment for his depression.

Current Significant Relationships

Although Abe had withdrawn somewhat from his family, his relationship with his two grown children and four school-age grandchildren were good. He sometimes visited them or attended his grandchildren's sporting events. He had a great deal of conflict with his ex-wife and had completely withdrawn from his two male friends. He was relatively close to one cousin and less so to one brother. He saw and spoke to his other brother and his mother infrequently and didn't feel close to them.

PART TWO: HISTORICAL INFORMATION

Best Lifetime Functioning (Including Strengths, Assets, and Resources)

Abe was at his best when he finished high school, got a job, and moved into an apartment with a friend. This period lasted for about 6 years. He did well on the job, got along well with his supervisor and coworkers, socialized often with good friends, exercised and kept himself in good shape, and started saving money for the future. He was a good problem solver, resourceful and resilient. He was respectful to others and pleasant to be around, often helping family and friends without being asked. He was hardworking, both at work and around the house. He saw himself as competent, in control, reliable, and responsible. He viewed others and his world as basically benign. His future seemed bright to him. He also functioned highly after this time, though he had more stress in his life after he married and had children.

History of Present Illness

Abe developed depressive and anxious symptoms 2½ years ago. His symptoms gradually worsened and turned into a major depressive episode about 2 years ago. Since that time, symptoms of depression and anxiety have remained consistently elevated without any periods of remission.

History of Psychiatric, Psychological, or Substance Use Problems and Impact on Functioning

Abe became quite anxious about 2½ years ago when his supervisor changed his job responsibilities and provided him with inadequate training. He began to perceive himself as failing on the job and became depressed. His depression increased significantly when he lost his job 6 months later. He withdrew into himself and stopped many activities: helping around the house, doing yard work and errands, and seeing his friends. His wife then became highly critical, and his depression became severe. He had not had any problems with alcohol or other substances.

History of Psychiatric, Psychological, or Substance Abuse Treatment, Type, Level of Care, and Response

Abe and his wife had had three joint outpatient marital counseling sessions with a social worker about 2 years ago; Abe reported it did not help. He reported no other previous treatment.

Developmental History (Relevant Learning, Emotional, and Physical Development)

Abe had no relevant difficulties in his physical or emotional development or in his school performance.

Personal, Social, Educational, and Vocational History

Abe was the oldest of three sons. His father abandoned the family when Abe was 11 years old, and he never saw his father again. His mother then developed unrealistically high expectations for him, criticizing him severely for not consistently getting his younger brothers to do homework and for not cleaning up their apartment while she was at work. He had some conflict with his younger brothers who didn't like him "bossing" them around. Abe always had a few good friends at school or in the neighborhood. After his father left, he developed a closer relationship with his maternal uncle and later with several of his coaches. Abe was an average student and a very good athlete. His highest level of education was a high school diploma. Abe started working in the construction industry in high school and had just a few jobs in the industry between graduation and when he became depressed. He worked his way up in customer service until he became a supervisor. He got along well with his bosses, supervisors, and coworkers and had always received excellent evaluations until his most recent supervisor.

Medical History and Limitations

Abe had a few sports-related injuries in high school but nothing major. His health was relatively good, except for moderately high blood pressure,

which he developed in his late forties. He didn't have any physical limitations.

Current Nonpsychiatric Medications, Treatment, Adherence, and Side Effects

Abe was taking Vasotec, 10 mg, 2 × per day, with full adherence to treat high blood pressure. He had no significant side effects. He was not receiving any other treatment.

PART THREE:
THE COGNITIVE CONCEPTUALIZATION DIAGRAM (CCD)

See pages 44–54.

PART FOUR: THE CASE CONCEPTUALIZATION SUMMARY

History of Current Illness, Precipitants, and Life Stressors

The first occurrence of Abe's psychiatric symptoms began 2½ years ago when Abe began to display mild depressive and anxious symptoms. The precipitant was difficulty at work; his new supervisor had significantly changed his job responsibilities, and Abe experienced great difficulty in performing his job competently. He began to withdraw from other people, including his wife, and started spending much of the time when he was home sitting on the couch. His symptoms steadily worsened and increased significantly when he lost his job and his wife divorced him, about 2 years ago. His functioning steadily declined after that. At intake, he was spending most of his time sitting on the couch, watching television, and surfing the web.

Maintaining Factors

Highly negative interpretations of his experience, attentional bias (noticing everything he wasn't doing or wasn't doing well), lack of structure in his day, continuing unemployment, avoidance and inactivity, social withdrawal, tendency to stay in his apartment and not go out, increased self-criticism, deterioration of problem-solving skills, negative memories, rumination over perceived current and past failures, and worry about the future.

Values and Aspirations

Family, autonomy, and productivity were very important to Abe. He aspired to rebuild his life, to recapture his sense of competence and ability to get things done, to get back to work, to become financially stable, to reengage in activities he had abandoned, and to give back to others.

Narrative Summary, Incorporating Historical Information, Precipitants, Maintaining Factors, and Cognitive Conceptualization Diagram Information

For most of his life, Abe demonstrated many strengths, positive qualities, and internal resources. For many years he had had a successful work history, marriage, and family. He had always aspired to be a good person, someone who was competent and reliable and helpful to others. He valued hard work and commitment. His strongly held values led to adaptive behavioral patterns of holding high expectations for himself, working hard, solving his problems independently, and being responsible. His corresponding intermediate beliefs were "If I have high expectations and work hard, I'll be okay. I should solve problems myself. I should be responsible." His core beliefs about the self were that he was reasonably effective and competent, likeable, and worthwhile. He saw other people and his world as basically neutral or benign. His automatic thoughts, for the most part, were realistic and adaptive.

But the meaning Abe put to certain adverse childhood experiences made him vulnerable to having his negative beliefs activated later in life. His father left the family permanently when Abe was 11 years old, which led him to believe that his world was at least somewhat unpredictable. His mother criticized him for failing to reach her unreasonably high expectations. Not realizing her standards were unreasonable, Abe began to see himself as not fully competent. But these two beliefs weren't rock solid. Abe believed that much of his world was still relatively predictable and that he was competent in other ways, especially in sports.

As an adult, when Abe began to struggle on the job, he became anxious, fearing that he wouldn't be able to live up to his deeply held values of being responsible, competent, and productive. The anxiety led to worry, which caused difficulties in concentration and problem solving, and his work suffered. He started to view himself and his experiences in a highly negative way and developed symptoms of depression. His core belief of incompetence/failure became activated, and he began to see himself as somewhat helpless and out of control. His negative assumptions surfaced: "If I try to do hard things, I'll fail"; "If I ask for help, people will see how incompetent I am." So, he began to engage in dysfunctional coping

strategies, primarily avoidance. These coping strategies helped maintain his depression.

Failing to be as productive as he thought he should be and avoiding asking for help and support from others, along with harsh criticism from his wife for not helping around the house, also contributed to the onset of his depression. He interpreted his symptoms of depression (e.g., avoidance, difficulty concentrating and making decisions, and fatigue) as additional signs of incompetence. Once he became depressed, he interpreted many of his experiences through the lens of his core belief of incompetence or failure. Three of these situations are noted at the bottom of the Cognitive Conceptualization Diagram.

Once Abe became depressed, he started to view other people differently. He feared that they would be critical of him, and he withdrew socially. Historically, he had seen his world as potentially unpredictable. After losing his job and his wife blindsiding him, he began to view his world as less safe (especially financially), less stable, and less predictable.

PART FIVE: TREATMENT PLAN

Overall Treatment Plan

The plan was to reduce Abe's depression and anxiety, improve his functioning and social interactions, and increase positive affect.

Problem List/Client's Goals and Evidence-Based Interventions

Unemployment/get a job. Examined advantages and disadvantages of looking for similar job as before versus initially getting a different job (one that would be easier to obtain and perform), evaluated and responded to hopeless automatic thoughts ("I'll never get a job and even if I do, I'll probably get fired again"), problem-solved how to update résumé and look for a job, and role-played job interview.

Avoidance/reengage in avoided activities. Scheduled specific tasks around the house to do at specific times and did behavioral experiments to test his automatic thoughts ("I won't have enough energy to do this"; "I won't do a good enough job on this"). Evaluated and responded to automatic thoughts (such as "Doing this will just be a drop in the bucket"). Scheduled social activities and other activities that could bring a sense of pleasure. Taught Abe to give himself credit for anything he did that was even a little difficult and keep a credit list.

Social isolation/reconnect with others. Scheduled times to get together with friends and family; assessed which friend would be easiest to contact, evaluated automatic thoughts ("He won't want to hear from me"; "He'll be critical of me for not having a job"), discussed what to say to friend about having been out of touch, and did behavioral experiments to test interfering thoughts.

Ongoing conflict with ex-wife/investigate whether improved communication skills can help/decrease sense of responsibility for divorce. Taught communication skills such as assertion and did behavioral experiments to test thoughts ("It won't make any

difference; she'll never stop punishing me/being mad at me"). Did a pie chart of responsibility.

Depressive rumination and self-criticism/reduce depressive rumination. Provided psychoeducation about symptoms and impact of depression, evaluated beliefs about deserved criticism, evaluated positive and negative beliefs about rumination and worry, did a behavioral experiment to see impact of mindfulness of the breath, and prescribed mindfulness exercise each morning and during the day as needed.

PART SIX: COURSE OF TREATMENT AND OUTCOME

Therapeutic Relationship

At the beginning of treatment, Abe was concerned that I might be critical of him, and he thought he should be able to overcome his problems on his own. I provided him with my view: that he had a real illness for which most people require treatment, that his difficulties stemmed from his depression and didn't indicate anything negative about him as a person, and that it was a sign of strength that he was willing to see if treatment could help. He seemed to be reassured. He demonstrated a level of trust in me from the beginning; he was open about his difficulties and collaborated easily. Initially, when he reported what he had accomplished on his Action Plans, he was skeptical when I suggested that these experiences showed his positive attributes. But he was able to recognize that he, too, would see these activities in a positive light if someone else in his situation had engaged in them. Abe mostly provided positive feedback at the end of sessions. He was able to appropriately let me know when I misunderstood something he said. In summary, he was able to establish and maintain a good therapeutic relationship with me.

Number and Frequency of Treatment Sessions, Length of Treatment

Abe and I met weekly for 12 weeks, then every other week for 4 weeks, and then once a month for 4 months, for a total of 18 sessions over 8 months. We had standard 50-minute CBT sessions.

Course of Treatment Summary

I suggested, and Abe agreed, that we work first on (1) getting Abe to get out of his apartment almost every day, (2) spending more time with his family, and (3) cleaning up his apartment. Doing these things increased his sense of connectedness and his sense of control and competence (and decreased his belief that he was incompetent and somewhat out of

control). (Later we worked on spending more time with friends and volunteering.) Increasing his social activities improved his social support and fulfilled his important values of close relationships and being helpful and responsible to other people. We also worked on decreasing his depressive rumination. Once he was functioning somewhat better, we worked on finding employment; he started off by doing construction for his friend's business. Our final goal was to see if he could improve his relationship with his wife—but he could not.

Measures of Progress

Abe scored 18 on the PHQ-9 and 8 on the GAD-7 at intake, and his sense of well-being on a 0–10 scale was 1. I continued to monitor progress by using these three assessments at every session. At the end of treatment, his PHQ-9 score was 3, his GAD-7 score was 2, and his sense of well-being score was 7. Although he still had some days that were difficult, on more days than not, he felt much better.

Outcome of Treatment

Abe's depression was almost in remission at the end of weekly treatment. He subsequently got a full-time job that he liked and did well in, was more engaged with friends and family, and felt much better. When he returned for his last monthly booster session, his depression was in full remission, and his sense of well-being had increased to an 8.

See *beckinstitute.org/CBTresources*.

APPENDIX C

Steps in the AWARE Technique

1. ***A*ccept anxiety.** Anxiety is natural, normal, and necessary for survival. The sensations you experience are a normal part of anxiety, even when they become intense. Anxiety increases when you get anxious about feeling anxious. But just because you feel anxious doesn't necessarily mean there's anything wrong. Your brain reacts in the same way whether it perceives actual danger or imagined danger. You can view anxiety as energy, given to help you deal with dangerous or difficult situations. Don't try to avoid, suppress, or control anxiety. If you do, it will become more intense and prolonged.
2. ***W*atch it from a distance.** Look at it without judgment—not good, not bad. Rate it on a 0–10 scale, and watch it go up and down. Be detached. Remember, you are not your anxiety. The more you can separate yourself from the experience, the more you can just watch it. Look at your thoughts, feelings, and actions as if you're a friendly, but not overly concerned, bystander.
3. ***A*ct constructively with it.** Act as if you aren't anxious. Whatever you can do without anxiety, you can do it with it. You can hold a conversation, do chores, walk, drive, exercise, dance, sing, pray, and write with anxiety. Breathe slowly and normally. Don't run away from

anxiety or avoid anxiety-provoking situations. If you do, you give yourself the message that anxiety is bad or dangerous.

4. ***R*epeat the above.** Continue to Accept, Watch, and Act constructively with the anxiety.
5. ***E*xpect the best.** Most of the time, what you most fear doesn't happen. Give yourself lots of opportunities to use the steps above so you can gain confidence that anxiety always decreases. And your difficulties with anxiety will decrease once you stop fighting it or trying to avoid or control it.

Adapted with permission from Beck and Emery (1985).

APPENDIX D

Restructuring the Meaning of Early Memories through Experiential Techniques

I have put techniques to restructure the meaning of early experience in an appendix because they are more advanced and may not apply to many of your clients. These Gestalt-type techniques have been adapted to the cognitive model, specifically to change dysfunctional beliefs, and are more often used with clients with personality disorders than with clients who have acute disorders, though not exclusively so. You use these techniques toward the middle or end of treatment, when clients have already begun to modify their dysfunctional beliefs. Note that it may be important for some clients to focus more heavily on recalling positive memories and deriving positive meanings to fortify their adaptive beliefs about themselves, their worlds, and/or other people. I present two ways to restructure the meaning of memories below.

Technique 1: Restructuring the Meaning of Early Experience through Reenactment and Therapist–Client Role Play. Below, I first ask Abe about a distressing situation, suggesting he focus on the somatic

sensations attached to his negative emotion to activate his core beliefs and distress more intensely. I do this so he can gain greater access to an earlier memory with the same theme.

JUDITH: Abe, you look pretty down today.
ABE: Yeah. My ex-wife called. I was supposed to babysit for my grandchildren this morning, but I had to cancel at the last minute because I had forgotten I had a doctor's appointment.
JUDITH: What did she say to you?
ABE: That I'm a terrible grandfather.
JUDITH: What went through your mind when she said that?
ABE: She's right. I *am* a terrible grandfather.
JUDITH: And how are you feeling?
ABE: [expressing her emotion] Sad. Real sad. [expressing his core belief] I'm such a failure.
JUDITH: Just as a grandfather or overall?
ABE: It feels like overall.
JUDITH: [heightening his affect to facilitate memory retrieval] Do you feel this sadness and failure somewhere in your body?
ABE: (*Points to chest.*) Here, in my chest. There's this heaviness.

Next, we collaboratively decide not to focus on this current situation at the moment. Instead, I take advantage of Abe's negative mood state to identify an important early experience, in which the same core belief had been activated. I ask him to imagine the scene. Then we discuss the memory on the intellectual level, and I help Abe see an alternative explanation for his mother's outburst in which she blamed and criticized him.

JUDITH: When is the first time you remember feeling this way, as a kid?
ABE: (*pause*) Probably when I was about 11 or 12. I remember my mother coming home really late from work because she had missed her bus. She got really upset with me because my brothers were playing with colored clay in the kitchen and it was all over the table and on the floor.
JUDITH: Can you picture the scene in your mind? Were you and your brothers and mom in the kitchen?

ABE: Yes.
JUDITH: What did her face look like? What did she say?
ABE: Well, she looked pretty mad. She really yelled. She said something like "Abe, what am I going to do with you? Just look at this place!"
JUDITH: What did you say?
ABE: I don't think I said anything. My mom kept yelling at me. She said something like "Don't you know how hard I work? I don't ask you to do much. But why did you let your brothers get clay all over the place. You should have been watching them. Is that really so hard to do?"
JUDITH: [empathizing] You must have felt pretty bad.
ABE: I did.
JUDITH: Do you think this was a reasonable way for her to act?
ABE: (*Thinks*.) I don't know … She was pretty tired and stressed out.
JUDITH: Is this something you found yourself saying a lot to your own kids?
ABE: No. I never said anything like that. I didn't expect them to look after each other.
JUDITH: Can you remember when your son was 11 years old—and your daughter was, what, 8?
ABE: Yes.
JUDITH: If you had come home one day after work, you were really late and really tired and stressed out, and the table and floor were covered with clay, what would you have said to them?
ABE: Umm … I guess I'd have said something like—"Uh-oh. Okay, there's clay all over the table and on the floor. Stop what you're doing and clean it up. And next time, don't let it get so messy."
JUDITH: That's really good. Do you have any idea why your mother didn't just ask *you* to clean up the clay?
ABE: I'm not sure.
JUDITH: I wonder, from what you've told me before, if it could be because she was overwhelmed with being a single parent. I wonder whether seeing the kitchen messy made her feel out of control.
ABE: That's probably right. It was hard for her.

Next, I change the focus so Abe can engage in experiential learning through role play. Initially he plays his mother; then we switch roles and he plays himself.

JUDITH: Okay, how about if we do a role play? I'll play you at age 11; you play your mom. Try to see things from her point of view as much as you can. You start. You've just come home from work, you see clay all over the table and the floor, and you say …

ABE: [as Mom] Abe, look at this mess. You should have stopped your brothers.

JUDITH: [as Abe] Mom, I'm sorry. It *is* a mess. I'll start cleaning it up.

ABE: Don't you know how hard I work? Is it really too much to expect you to watch your brothers?

JUDITH: I *was* watching them, and I did tell them to clean up, but they wouldn't listen to me.

ABE: You have to make them.

JUDITH: I don't know how to do that. I'm only 11. You're expecting too much from me. I'll clean it up now. I don't know why you're making such a big deal out of this. You're making me feel like such a failure. Is that what you think I am?

ABE: No, I don't want you to think that. It's not true. I just want you to do better.

Next, I help Abe draw a different conclusion about the experience:

JUDITH: Okay, out of role. What do you think?

ABE: I wasn't really a failure. I did most things okay. Mom was probably just really stressed.

JUDITH: How much do you believe that?

ABE: I think I do believe it.

JUDITH: How about if we do the role-play again, but this time we'll switch parts. You be your 11-year-old self, and let's see how well you can talk back to your mom.

Following this second role play, I ask Abe to summarize what he learned. Then we discuss how his conclusions apply to the current situation in which his ex-wife called him a failure.

Technique 2: Restructuring the Meaning of Early Experience through Reenactment and Older Client–Younger Client Role Play. This technique starts out in the same way. Here are the steps:

1. Identify a specific situation that is currently quite distressing to a client and is associated with an important dysfunctional belief. Heighten the clients' affect by focusing on her automatic thoughts, emotions, and somatic sensations.

2. Help the client identify a relevant early experience by asking, "When do you remember feeling like this when you were growing up?" or "When is the earliest time you remember believing this about yourself? [or 'When did your belief get much stronger?']" Elicit a description of a specific situation and the meaning the client put to it. Use Socratic questioning to help her reframe the dysfunctional belief that had been activated.

3. Ask the client to reexperience the situation as if she is the child (the "younger self") and as if it is happening to her right then. Until you're finished with the technique, speak to the younger self using vocabulary and concepts appropriate for her developmental level. As she tells you about the experience, elicit automatic thoughts, emotions, and beliefs of the younger self. Ask her to rate how much she believes her beliefs. (You often need to give the younger self a multiple choice: "Do you believe it a little? A medium amount? A lot?" If you ask the younger self for a percentage, she will mentally shift to her older [current] self.) Ask the client to continue to imagine the scene, always speaking as the younger self, using the present tense, until the trauma is over and she's in a safer place.

4. Ask the younger self if she wants to have her older self come into the scene (the safer place) and help her understand what happened. Facilitate a dialogue between the younger self (the emotional mind) and the older self (the intellectual mind) to reframe the dysfunctional belief. If the younger self is confused or doesn't believe her older self, make suggestions to the older self about what she can say (using developmentally appropriate language and concepts).

5. Ask the younger self to re-rate how much she *now* believes the dysfunctional belief. If her degree of belief has reduced, ask the younger self if she has anything else she wants to ask or say to her older self; then facilitate their saying good-bye.

6. Ask the client, “What do you conclude from what we’ve just done?” A typical conclusion is that the dysfunctional belief was not true, or certainly, not completely true, and that the younger self was vulnerable and deserved protection and good treatment. The client may also agree to begin talking to herself in a more compassionate manner (in the way her older self talked to her younger self) as part of her Action Plan.

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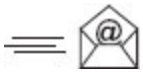

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Description of image for Figure 3.3

The diagram shows a circle, labeled “I’m incompetent.” Two negative data: “Difficulty reading text” and “Thinking of applying for a bank loan” directly enter the circle. Two positive data: “Sessions with a client went well” and “Finished reading text” are converted into negative data as “But it’s because she’s so eager to please me” and “But it took me so long.” These converted data then enter into the circle, “I’m incompetent” Two other positive data: “Finished paperwork” and “Figured out ambiguous diagnosis” are rejected back on its entry to “I’m incompetent.”

Navigate back to the page.

Description of image for Figure 3.4

The flow starts with Relevant Life History and Strengths, Assets. From here it flows down to Adaptive core beliefs (prior to onset of current difficulties) and then to the Adaptive intermediate beliefs: Rules, Attitudes, Assumptions (prior to onset of current difficulties) and flows to Adaptive patterns of behavior (prior to onset of current difficulties).

The Relevant Life History reads (including accomplishments, strengths, personal qualities, and resources prior to current difficulties): People described Abe as "a good kid." Some positive interactions with family, maternal uncle, and coaches growing up. Took father's abandonment in stride. Tried hard when given age-inappropriate responsibilities at home at age 11. Good friends, average grades, above-average athlete, high school diploma. Likeable, a "good family man"; good relationships with children/grandchildren, a cousin, two male friends; made a reasonable living; always budgeted and saved money.

The Strengths, Assets reads Strongly motivated, good sense of humor, liked by most people. Sees two grown children and four grandchildren often, helps them out, close relationships with them, a cousin, and several male friends. Had made a reasonable living; always budgeted and saved money. Highly motivated. Excellent work history; many interpersonal, organizational, and supervisory skills; reliable and responsible. Good problem-solver and good common sense.

Adaptive core beliefs (prior to onset of current difficulties) reads "I'm responsible, considerate, competent, self-reliant, helpful, a good person, likeable, resourceful. Most people are neutral or benign. The world is potentially unpredictable but relatively safe and stable. I can cope (if bad things happen)."

Adaptive intermediate beliefs: Rules, Attitudes, Assumptions (prior to onset of current difficulties) reads "Family, work, and community are important. It's important to work hard, be productive, self-reliant,

responsible, and reliable, honor commitments, consider others' feelings, do the right thing; do what I say I'm going to do. I should figure things out for myself. If I persist on a difficult task, I'll probably succeed. If I perform highly, it means I'm competent; I'm okay."

Adaptive patterns of behavior (prior to onset of current difficulties) reads Sets high standards for himself, works hard, tries to increase his competence, perseveres and solves problems himself; is kind and considerate to others, honors his commitments, does what he sees as "the right thing," helps others.

From Adaptive patterns of behavior (prior to onset of current difficulties) three Situations are branched out and from each Situation the flow covers Automatic though(s), Emotions, and Behavior.

The first branch shows the flow as follows.

SITUATION 1: Thinking about meeting buddies for breakfast.

AUTOMATIC THOUGHT(S): "I'm really tired, but I don't want to disappoint them."

EMOTIONS: Neutral.

BEHAVIOR: Goes to breakfast.

The second branch shows the flow as follows.

SITUATION 2: Fixing neighbor's car

AUTOMATIC THOUGHT(S): "I don't know if I can get it to run."

EMOTIONS: Neutral.

BEHAVIOR: Keeps trying.

The third branch shows the flow as follows.

SITUATION 3: Surfing the Web

AUTOMATIC THOUGHT(S): “I’d like a better TV, but I have to cover my bills.”

EMOTIONS: Mild disappointment.

BEHAVIOR: Doesn’t order TV.

Navigate back to the page.

Description of image for Figure 3.5

The flow starts with Relevant Life History. From here it flows down to Adaptive core beliefs (prior to onset of current difficulties) and then to the Adaptive intermediate beliefs: Rules, Attitudes, Assumptions (prior to onset of current difficulties) and flows to Adaptive patterns of behavior (prior to onset of current difficulties).

The Relevant Life History reads (including accomplishments, strengths, personal qualities, and resources prior to current difficulties): What experiences contributed to the development and maintenance of the adaptive core belief(s)? What have the client's strengths, skills, personal and material assets, and positive relationships been like? What are the client's skills, strengths, and positive qualities? What internal and external resources does the client have?

Adaptive core beliefs (prior to onset of current difficulties) reads What are the client's most central adaptive beliefs about him/herself? Others? The world?

Adaptive intermediate beliefs: Rules, Attitudes, Assumptions (prior to onset of current difficulties) reads What general assumptions, rules, attitudes, and values does the client have?

Adaptive patterns of behavior (prior to onset of current difficulties) reads What adaptive coping strategies and behaviors does the client display?

From Adaptive patterns of behavior (prior to onset of current difficulties), three Situations are branched out and from each Situation the flow covers Automatic though(s), Emotions, and Behavior.

The first branch shows the flow as follows.

SITUATION 1: What was the problematic situation?

AUTOMATIC THOUGHT(S): What went through the client's mind?

EMOTIONS: What emotions were associated with the automatic thought?

BEHAVIOR: What did the client do that was helpful?

The second and third branch shows blank for all its components.

Navigate back to the page.

Description of image for Figure 3.7

The flow starts with Relevant Life History and Precipitants. From here it flows down to Core Belief(s) (during current episode) and then to the Intermediate Beliefs: Conditional Assumptions/Attitudes/Rules (during current episode) and flows to Coping Strategies (during current episode).

The Relevant Life History and Precipitants reads Father leaves family when Abe is 11 years old. He never sees him again. Mom is overburdened, very critical when he can't meet her unrealistic expectations. Precipitants to current disorder: Abe struggles and then loses his job and undergoes divorce.

The Core Belief(s) (during current episode) reads "I'm incompetent/a failure."

The Intermediate Beliefs: Conditional Assumptions/Attitudes/Rules (during current episode) reads "It's important to be responsible, competent, reliable, and helpful." "It's important to work hard and be productive."

During depression:

(1) "If I avoid challenges, I'll be okay, but if I try to do hard things, I'll fail."

(2) "If I avoid asking for help, my incompetence won't show, but if I do ask for help, people will see how incompetent I am."

The Coping Strategies (during current episode) reads Avoids asking for help and avoids challenges.

From Coping Strategies (during current episode), three Situations are branched out and from each Situation the flow covers Automatic though(s), MEANING OF A.T., Emotions, and Behavior.

The first branch shows the flow as follows.

SITUATION 1: Thinking about bills.

AUTOMATIC THOUGHT(S): “What if I run out of money?”

MEANING OF A.T: “I’m a failure.”

EMOTIONS: Anxious

BEHAVIOR: Continues to sit on couch; ruminates about his failures

The second branch shows the flow as follows.

SITUATION 2: Thinking of asking son for help in revising resume.

AUTOMATIC THOUGHT(S): “I should be able to do this on my own.”

MEANING OF A.T: “I’m incompetent.”

EMOTIONS: Sad

BEHAVIOR: Avoids asking son for help.

The third branch shows the flow as follows.

SITUATION 3: Memory of being criticized by boss

AUTOMATIC THOUGHT(S): “I should have tried harder.”

MEANING OF A.T: “I’m a failure.”

EMOTIONS: Sad

BEHAVIOR: Ruminates about what a failure he was.

An arrow from the CORE BELIEF(S) (during current episode): “I’m incompetent/a failure.” Flows directly to the first branch of AUTOMATIC THOUGHT(S): “What if I run out of money?”

Navigate back to the page.

Description of image for Figure 3.8

The flow starts with Relevant Life History and Precipitants. From here it flows down to Core Belief(s) (during current episode) and then to the Intermediate Beliefs: Conditional Assumptions/Attitudes/Rules (during current episode) and flows to Coping Strategies (during current episode).

The Relevant Life History and Precipitants reads Which experiences contributed to the development and maintenance of the core belief(s)?

The Core Belief(s) (during current episode) reads What are the client's most central dysfunctional beliefs about him/herself? Other people? The world?

The Intermediate Beliefs: Conditional Assumptions/Attitudes/Rules (during current episode) reads Which assumptions, rules, and beliefs help him/her cope with the core belief(s]?

The Coping Strategies (during current episode) reads Which dysfunctional behaviors help him/her cope with the belief(s)?

From Coping Strategies (during current episode) three Situations are branched out and from each Situation the flow covers Automatic though(s), MEANING OF A.T., Emotions, and Behavior.

The first branch shows the flow as follows.

SITUATION 1: What was the problematic situation?

AUTOMATIC THOUGHT(S): What went through his/her mind?

MEANING OF A.T: What did the automatic thought mean to him/her?

EMOTIONS: Which emotion(s) were associated with the automatic thought(s)?

BEHAVIOR: What did the client do then?

The second and third branch shows blank for all its components.

An arrow from the CORE BELIEF(S) (during current episode): “I’m incompetent/a failure.” Flows directly to the first branch of AUTOMATIC THOUGHT(S): “What if I run out of money?”

Navigate back to the page.

Description of image for Figure 3.9

The Situation is branched out into two Automatic Thoughts and this is further branched into Emotion and Behavior, respectively.

• The Situation reads, Charlie cancels Sunday breakfast.

• The first automatic thought reads “What if there’s something wrong?”

• The second automatic thought reads “He probably doesn’t want to get together.”

• The first emotion is Anxiety.

• The first behavior is nothing.

• The second emotion is Sadness.

• The second behavior is Sits on couch and ruminates.

Navigate back to the page.

Description of image for Figure 3.10

The flow is as follows.

• CORE BELIEF(S)

“I’m incompetent.”

• INTERMEDIATE BELIEFS: CONDITIONAL ASSUMPTIONS/ATTITUDES/RULES

“It’s terrible to fail.”

“I should give up if a challenge seems too great.”

“If I set low goals for myself, I’ll be okay, but if I set high goals, I’ll fail.”

“If I rely on others, I’ll be okay, but if I rely on myself, I’ll fail.”

“If I avoid difficult tasks, I’ll be okay, but if I don’t, I’ll fail.” The flow continues.

• COPING STRATEGIES: Developing low standards, relying on others, avoiding hard work

• SITUATION: Reads CBT textbook

• AUTOMATIC THOUGHT(S): “This is just too hard. I’m so dumb. I’ll never master this. I’ll never make it as a therapist.”

• MEANING OF A T: “I’m incompetent.”

• EMOTIONS: Sad

• BEHAVIOR: Turns on the television.

Navigate back to the page.

Description of image for Page 100

These four components are relatively compared with the conversation between Abe and Judith.

Situation: Think about doing something, like taking grandchildren out.

Automatic thoughts: “Everything is too hard.”

Emotion: Depressed.

Behavior: Stays sitting on couch.

The automatic thoughts, Emotion, and Behavior are interlinked to each other.

Navigate back to the page.

Description of image for Figure 6.2

The action plan dated, May thirteenth reads as follows.

Read this Action Plan and the one from last week twice a day.

Continue to give myself credit.

How my thoughts affect my reaction

• Situation: Thinking about doing something, like taking grandchildren out

• Automatic thoughts: “Everything is too hard.”

• Emotion: Depressed.

• Behavior: Stay sitting on couch.

The automatic thoughts, emotion, and behavior are interlinked to each other.

When I criticize myself, remember I’m only looking at part of the scene, and it’s through black glasses. Judy says it’s not my fault that I’m doing this. It’s happening because I have depression.

When I notice my mood is getting worse or I’m doing something unproductive, ask myself, “What’s going through my mind right now?” and write down my thoughts on the Identifying Thoughts Worksheet. Wear a rubber band to remind me to do this.

Remember, black glasses. A drawing shows black glasses.

If I’m feeling really tired and feel like staying on the couch instead of going out—or doing something else—remind myself that I have to get back into the world. It’s important to go. Not going will probably keep me depressed. I want to get back into the world so I can be productive, be

better to my family. I'll feel more useful and competent and in control. Going out may or may not affect my mood right away. I may need to crank up the jack-in-the-box.

To do:

1. Take Ethan out for ice cream.

2. Go out four times this week. For example, take a 5-minute walk, go to the grocery store, or go to the hardware store. Demonstrate to myself that I can take control and do things.

3. Look at the goal list. Do I want to add or cross off or change any?

Navigate back to the page.

Description of image for Page 118

The Situation includes Thinking about initiating an activity.

The common Automatic Thought includes “I’m too tired.” “I won’t enjoy it.” “My friends won’t want to spend time with me.” “I won’t be able to do it.” “Nothing can help me feel better.”

The common Emotional reactions include Sadness, anxiety, and hopelessness.

The common Behavior includes Remain inactive.

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Description of image for Page 119

The three components are Behavior/Situation, Negative Thoughts, and Depressed Mood. The Behavior/Situation includes Inactivity/Recognizing Inactivity.

Navigate back to the page.

Description of image for Page 119

The three components are Behavior/Situation, Positive Thoughts, and Increased Hopefulness. The Behavior/Situation includes Increased Activity/Recognition of Increased Activity.

Navigate back to the page.

Description of image for Page 120

The situation includes Engaging in an activity.

The common automatic thought includes “There’s no point in doing this.” “I’m doing a terrible job.” “I should have done this long ago.” “There’s still so much left to do.” “I can’t do this as well as I used to.” “This used to be more fun.” “I don’t deserve to be doing this.”

The common emotional reactions include Sadness, anxiety, guilt, anger at self.

The common behavior includes Stop the activity. Fail to repeat this activity in the future.

Navigate back to the page.

Description of image for Figure 12.1, Image 1

The flow is as follows.

• Situation: Friend calls Annie to cancel lunch and shopping.

• Automatic thought: “She doesn’t want to see me.”

• Emotion: Sadness.

• Additional automatic thoughts: “This is the second time she’s done that. She’s being inconsiderate.”

• Emotion: Irritability.

• Situation: Realizes she has no backup plan.

• Automatic thought: “Now what am I going to do this afternoon?”

• Emotion: Anxiety.

• Situation: Thinks about what to do.

• Automatic thoughts: “I really should go pay the bills. But what if I don’t have enough money in the checking account?”

• Emotion: Anxiety.

• Behavior: Sits on couch and obsesses over lack of money.

• Physiological response: Tension in body.

• Situation: Notices how she’s feeling.

The flow continues.

Navigate back to the page.

Description of image for Figure 12.1, Image 2

The flow continues as follows.

• Automatic thought: “I don’t like feeling this way.”

• Emotion: Increased anxiety.

• Physiological response: Increased tension

• Automatic thought: “I want a glass of wine. But it’s too early to start drinking.”

• Emotion: Increased anxiety.

• Physiological response: Increased tension.

• Automatic thought: [permission giving thought] “There’s nothing else I can do to get rid of this feeling. I might as well go get some [wine].”

• Emotion: Partial relief.

• Physiological response: Slight reduction in tension.

• Behavior: Gets a glass of wine and drinks it quickly.

• Automatic thought: “That feels better.”

• Emotion: Relief.

• Physiological response: Reduction of tension.

The flow goes on.

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Description of image for Page 231

The following are the rating for different level of emotions.

1 and 2: A little, 3 through 5: A medium amount, 7: A lot, 9 and 10: Completely. The rating 6 lies between the emotion levels: A medium amount and A lot, while rating 8 lies between A lot and Completely.

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Description of image for Figure 17.1

The flow starts from the Lifetime experiences and ends at Reaction.

• Lifetime experiences: Abe did well enough at school, excelled at sports, was very helpful to others, got excellent job reviews, was a good problem-solver, and worked hard.

• Core belief: “I’m competent.”

• Historical situation: Thinking about new responsibilities as a supervisor.

The flow enters into a section labeled, “Schema” and the flow continues.

• Interpretation of experience through screen of core belief.

• Automatic thought, “I’ll do a good job.”

• Reaction.

An arrow from Core belief directly flows to the Automatic thought.

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Description of image for Figure 17.2

The flow starts from the Lifetime experiences and ends at Reaction.

• Lifetime experiences: Mother yelled when the house was messy or brothers were out of control.

• Core belief: “I’m competent.”

• Historical situation: Thinking about unpaid bills.

The flow enters into a section labeled, “Schema” and the flow continues.

• Interpretation of experience through screen of core belief.

• Automatic thought, “I can’t believe I haven’t paid them yet.”

• Reaction.

An arrow from Core belief directly flows to the Automatic thought.

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Description of image for Page 316

The values on the number line relate as follows: zero percent: Never works, harms others; 20 percent: Lives off family money; 40 percent: Jeremy; 60 percent: Abe; 90 percent: Abe with job.

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Description of image for Figure 19.2

The staircase consists of six steps that read the following metaphor from down to up.

• Talk to my neighbor about moving.

• Figure out how much rent I can afford.

• Look online for apartments.

• Call to make appointment to visit.

• Visit one potential apartment.

• Visit another potential apartment.

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Description of image for Figure 19.4

The first pie chart is titled, “Ideal Expenditure of time.” The chart is divided into seven segments. The data from the chart are as follows:

• Work or School or Intellectual Side: 50 percent.

• Friend: 25 percent.

• Fun: 12.5 percent.

• Other Interests: 3.125

• Spiritual: 3.125

• Household,: 3.125.

• Physical: 3.125.

Note: All values are estimated.

The second pie chart is titled, “Actual Expenditure of time.” The chart is divided into seven segments. The data from the chart are as follows:

• Work/School/Intellectual Side: 80 percent.

• Friends: 5 percent.

• Fun: 5 percent.

• Other Interests: 2.5 percent.

• Spiritual: 2.5 percent.

• Household,: 2.5 percent.

• Physical: 2.5 percent.

Note: All values are estimated.

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Description of image for Figure 19.5

The chart is divided into four segments and infers the following data.

• Personality: 25 percent.

• Hair Trigger: 25 percent.

• Divorce Hasn’t Made Her Happier: 30 percent.

• Losing My Job: 20 percent.

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Description of image for Figure 20.1

The vertical and horizontal axes of the graph represent Improvement and Time, respectively. The graph shows a progressive trend with a lot of rises and falls, along with a few stable trends.

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